

SOUTH CENTRAL REGION
EMS & TRAUMA CARE SYSTEM
BIENNIAL PLAN



July 2005 – June 2007

Submitted by South Central Region EMS & Trauma Care Council
Rev. August 2005

Washington State DOH Approved Plan Modifications

To The South Central Region EMS And Trauma Care Plan

| Modification | Page Number (s) | Approved | Posted |
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I. Executive Summary

The South Central Region EMS & Trauma System Plan addresses the continuum of EMS and trauma care: prevention of injury, the 9-1-1 emergency dispatch system, EMS response and care system, trauma designated trauma service system, trauma designated rehabilitation service system, trauma system evaluation with the regional CQI process, and all hazards preparedness.

Authority - The Regional Council has been the recognized leader in regional EMS & Trauma System planning, development, and implementation since 1991. RCW and WAC identify and define the Regional Council's role. Continued leadership by the Regional Council is a system need.

Injury Prevention & Public Education - The Regional Council supports injury prevention through agreements and contracts with four SAFE KIDS Coalitions within the Region. Injury Prevention activities include projects in the four major injury and death categories of motor vehicle crashes, falls, poisoning and drowning. Other organizations in the region are also involved in injury prevention efforts. Focused funding is an ongoing need for future injury prevention support.

Prehospital

Communications – The South Central Region utilizes the VHF HEAR Radio for primary ambulance to trauma service communications. The 800 MHz radio is used in the Tri Cities area in addition to the HEAR radio. Cell phones are a common source of EMS communications from the field to the trauma service. There is a great need throughout the Region to update, enhance and replace equipment for the emergency communication system in the Region and in the State. Emergency Medical Dispatcher training is a need that the Regional Council promotes to emergency dispatch centers.

Medical Direction - The South Central Region has five County Medical Program Directors, who provide medical direction of prehospital providers under RCW and WAC. They all have developed county medical care protocols. The MPDs participate in local trauma system planning, but there is a need for their involvement at the Regional Council level for regional system planning.

Prehospital EMS & Trauma Services –

The South Central Region has developed and implemented a three tiered EMS & Trauma Care System that provides an organized EMS response. It includes First Responder Aid Services as responding first to the scene of a trauma, followed by BLS ambulances, which have rendezvous agreements with ILS/ALS ambulances so that the trauma patient is ultimately transported to a trauma service by an ALS ambulance. The Regional Council facilitates EMS continuing medical education (CME) and ongoing trauma education programs (OTEP) through established contracts with the five local EMS and trauma care councils. The local councils also facilitate frequent initial EMS training throughout the Region. In spite of the current efforts, recruitment and retention of volunteer EMS providers is always a challenge and need. Funding support for EMS CME is an ongoing regional need.

Verified Aid & Ambulance Services – The Regional Council evaluates geographic location, response times, and transport times to trauma services and recommends minimum and maximum numbers and types of verified EMS services per county. The Regional Council works with County Councils to identify Trauma Response Areas and the need for new services and EMS skill levels. Maps have been developed to distinguish those areas. Detailed mapping is needed to support future planning.

Patient Care Procedures - Twelve Regional Patient Care Procedures have been developed to provide specific directions for how the trauma system should function within the Region. Four local EMS & Trauma Care Councils have developed County Operating Procedures, with their MPDs, that provide specificity about local EMS agency operation in the Regional EMS and Trauma Care system. The Regional Council has Regional Guidelines that guide input and update of the Regional EMS and Trauma System plan and PCPs. MPD involvement is needed at the Regional level to ensure the PCPs meet the needs of the whole regional system.

Designated Trauma Services - Regional trauma services range from modern hospital medical centers in the urban/suburban cities, to small rural hospitals, to rehabilitation services. There are nine (9) designated trauma services in the South Central Region, however, many trauma services have designated at levels below the original recommendations of the Regional Council. The Regional Council continues to encourage under-designated trauma services to work toward increasing designation levels as originally identified as a need and planned for in the optimal regional system.

EMS & Trauma Evaluation - Information Management – Designated trauma services in the region collect and submit both EMS and trauma service data to the State Trauma Registry. The Regional Council is participating in planning for the Washington EMS Information System (WEMSIS) which will result in comprehensive collection of EMS data from participating EMS agencies. Both EMS and hospital data are needed in the region to be able to analyze regional system status and identify needs.

Quality Assurance - The Regional trauma services provide regional Continuous Quality Improvement through a CQI Committee that meets quarterly to analyze trends, review Trauma Registry statistics, and identify Regional trauma system issues. Comprehensive data collection is needed to enable the CQI committee to best analyze the EMS & Trauma System and provide information needed by the Regional Council for use in regional system planning.

All Hazards Preparedness - Prehospital Preparedness – The Regional Council has appointed an All Hazards Committee comprised of both EMS and Trauma Service representatives. There is a need for the committee to determine its direction for the future.

Hospital Preparedness – The Public Health Region 8 Bioterrorism Committee has developed a hospital preparedness plan and identified and prioritized equipment and supply needs for the trauma services. It will need to continue to work on future direction and needs.

2005-2007 Regional EMS and Trauma Care System Goals

Authority

- A functional and implemented EMS & Trauma Care System Plan within the region.
- System cost can be estimated

Injury Prevention

- Decrease death and injury due to the top four categories of MVC, falls, poisoning, and drowning.
- Increase the use of child safety restraints throughout the Region to decrease the number of deaths and injury due to unrestrained children in MVCs.
- Increased helmet usage throughout the Region to decrease serious head injury.
- Prevent child/pedestrian incidents by increased visibility of children during low light time by providing “Wildfeet” stickers.
- Increase public awareness through activities and programs to prevent falls, especially in the elderly.
- Increase public awareness of activities to protect children from accidental poisoning.
- Increase public awareness of activities designed to reduce drowning deaths and near drowning injuries.
- Provide IPPE messages in other languages in addition to English.
- Provide information about the new National Suicide Prevention Lifeline

Prehospital

Communication

- Enhance day to day and disaster communication capabilities between emergency dispatch, EMS vehicles, hospitals, and between EMS agencies and other responding entities.
- All emergency medical calls are handled by trained Emergency Medical Dispatchers who provided appropriate pre-arrival instructions from simple first aid to life saving instructions.

Medical Direction

- MPD awareness of Regional Council activities.

Trauma Verified EMS Services

- Recruit and retain EMS providers.
- Basic and State of the Art EMS equipment
- Updated training/education aids and equipment are available in the Region.

- Trauma Verified EMS Services that are available at the appropriate level in all areas of the Regional system.

PCPs

- Patient Care Procedures and County Operating Procedures meet the needs for excellent patient care in the South Central Region.

Designated Trauma Services

- Trauma Services that are designated at the recommended numbers and levels in the South Central Region.

Information Management

- Regional Trauma Registry Data available for trauma system planning and for system CQI.
- Timely accurate data collection and submission for use by the regional CQI Committee.
- Confidential regional CQI meetings and activities.

All Hazards Preparedness

- EMS: Protect the health and welfare of the population of Public Health Region 8, the South Central Region, and ease the effects of public health emergencies that may include Bioterrorism events.
- Hospitals: Protect the health and welfare of the population of Public Health Region 8 and the South Central Region, and ease the effects of public health emergencies that may include Bioterrorism events.

Summary of Proposed Changes to Plan Requiring DOH approval

- There are no proposed changes to the Plan requiring DOH approval.



II. Authority

A. Regional Council Coordination

1. System Status

RCW 70.168 and WAC 246-976-960 give authority and the direction for the South Central Regional Council. RCW further describes the composition of the Regional Councils and outlines their responsibilities. The Regional Councils are to develop and implement the Regional EMS and trauma system; identifying the need for and recommending the distribution and level of EMS agencies; and to recommend the distribution and levels of trauma services within each Region. Regional Councils are instructed to seek input from local EMS & Trauma Care Councils that include EMS providers, hospital providers, and others involved in trauma system development.

WAC states that regional Councils will have three mandatory membership categories-EMS provider, hospital representative, and local government official. The South Central Regional Council's membership allows for five representatives from each of the five local EMS & Trauma Care Councils. In addition to the three mandatory membership categories, the South Central Region has other categories that include County EMS director, County Medical Program Director (MPDs), EMS educator and others involved in trauma system development and implementation. The Regional Council holds meetings every other month on the 4th Thursday of the month.

The Regional Council facilitates EMS & Trauma System planning and implementation through a system with elected officers, Chairman, Vice Chairman, and Treasurer, and utilizes a committee structure to do the Council's work. The South Central Region has the following committees: Administration Committee, All Hazards Committee, By-Laws Committee, Communication Committee, Injury Prevention Committee, Training and Education Committee, and the Planning & Standards Committee with its subcommittees of Trauma Plan Review Committee and Patient Care Procedure Committee.

The Regional Council maintains an office with a hired staff consisting of an administrator and a part time secretary to carry out the day- to-day operation and manage the contracts for the Regional Council. Funding for the Regional Council is totally through a contract with the Department of Health.

The EMS and Trauma System Plan is updated at least every two years. The South Central Regional Council seeks updates and input from the local EMS & Trauma Care Councils, Medical Program Directors (MPDs), and others involved in the trauma system process. The Regional Council strives to assure that the Trauma System Plan reflects the ever-changing and on-going process of trauma care.

Since 2003, the Regional Council has been working collaboratively with local public health officials, county emergency management departments and other organizations that are involved in Bioterrorism/All Hazards preparedness planning and activities within Public Health Region 8.

MISSION STATEMENT

The Regional Council has adopted and amended the Department of Health's Mission Statement to reflect the Region. The mission Statement is as follows:

To establish, promote, and maintain a system of effective Emergency medical and trauma care services. Such a system provides timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury, and recognizes the changing methods and environment for providing optimal emergency care throughout the South Central Region and the State of Washington.

The South Central Region EMS & Trauma Care Council wholeheartedly endorses this mission statement and adds this additional Regional vision -*To minimize the human suffering and costs associated with preventable trauma related mortality and morbidity.* To accomplish the mission and vision, the Regional Council has developed and implemented the EMS and Trauma Care System Plan.

2. Need Statement

The greatest identified need of the EMS & Trauma Care System is the continuation of the coordination of projects and activities of trauma system development and implementation. The South Central Regional Council is recognized as the leader in EMS & Trauma System development in the Region. As changing times cause changes in the delivery of EMS & Trauma Care, the communities will look to the Regional Council for assistance in planning and implementing changes. To continue in a leadership role, maintain the EMS training and injury prevention contracts, and fulfill the responsibilities given to the Regional Council, grant funds need to stay at their current levels.

The Regional Council does not have the technical nor financial resources to provide accurate and realistic costs for the components that comprise a region-wide EMS & Trauma System.

3. Goals

Goal 1: A functional and implemented EMS & Trauma Care System Plan within the South Central Region.

Objective 1: Maintain and expand the EMS & Trauma System as described in the goals and objectives of this EMS & Trauma Care System Plan and report ongoing progress in scheduled progress reports to DOH in Attachment 2 of the DOH Contract monthly report.

Strategy 1: The South Central Region will continue its role as described in RCW and WAC.

Goal 2. Estimated system costs

Objective 1. Identify methods that will provide information on system costs by November 2006 and incorporate estimated system cost in the 2007-2009 biennial plan.

System Costs

System costs are not currently available.

Regional Council Costs

The Regional Council's annual operating budget is approximately \$244,594. Department of Health gives the South Central Region \$214,000 to develop, implement and maintain an EMS & Trauma Care System. The Regional Council has received \$45,000 from DOH for participation in All Hazards Preparedness. The Regional Council's budget includes \$75,866 for EMS training through its five local EMS & Trauma Councils; \$33,000 to its four SAFE KIDS Coalitions for Injury Prevention and Public Education activities; \$3,000 to the five local EMS & Trauma Councils to help off set local council mailing and meeting costs; \$1,000 for Data Collection activities; \$119,700 to maintain the Regional Council office; and \$45,000 for a contractor for All Hazards Preparedness.

Barriers - Barriers to EMS development in the South Central Region include political climate and lack of human and financial resources.

III. Injury Prevention/Public Education

A. IPPE

1. System Status

Table A. Regional Injury Data From Washington State Vital Statistics 2002

| Fatal Injuries 1998-2002 | Benton | Columbia | Franklin | Kittitas | Walla Walla | Yakima | Six County Total | WA State Total |
|-------------------------------------|---------------|-----------------|-----------------|-----------------|------------------------|---------------|---------------------------------|-------------------------------|
| Suicide | 11.6 | * | 6.5 | 11.2 | 15.2 | 12.2 | 11.7 | 12.8 |
| Motor Vehicle | 11.6 | 33.3 | 17.8 | 13.6 | 10.9 | 14.5 | 13.7 | 9.2 |
| Falls | 6.6 | * | * | 6.5 | 11.6 | 4.9 | 5.9 | 7.0 |
| Poison | 5.3 | * | 4.0 | * | 2.5 | 5.9 | 5.0 | 6.9 |
| Fire/Burn | 6.6 | * | * | * | * | 1.2 | 0.7 | 1.0 |
| Drowning | 4.7 | * | * | * | 1.8 | 2.0 | 1.8 | 1.8 |
| Pedestrian | * | * | * | * | * | 0.4 | 0.3 | 1.4 |

| Non-Fatal Injury Hospitalizations 1998-2002 | Benton | Columbia | Franklin | Kittitas | Walla Walla | Yakima | Six County Total | WA State Total |
|--|---------------|-----------------|-----------------|-----------------|------------------------|---------------|---------------------------------|-------------------------------|
| Suicide | 65.9 | 47.6 | 44.5 | 21.9 | 69.1 | 46.8 | 52.7 | 48.5 |
| Motor Vehicle | 42.2 | 95.1 | 72.4 | 46.2 | 48.5 | 66.3 | 57.1 | 46.4 |
| Falls | 254.6 | 447.2 | 246.1 | 254.4 | 325.2 | 300.7 | 283.3 | 281.0 |
| Poison | 24.7 | * | 19.0 | 18.3 | 18.5 | 26.8 | 23.9 | 35.4 |
| Fire/Burn | 10.5 | * | 15.0 | 8.9 | 5.8 | 14.6 | 12.0 | 9.9 |
| Drowning | 0.7 | * | 2.8 | * | * | 1.1 | 1.1 | 0.9 |
| Pedestrian | 0.7 | * | * | * | * | 1.2 | 1.0 | 7.3 |
| Bike/Vehicle | 1.1 | * | * | * | | 2.0 | 5.4 | 1.7 |

Source: Washington State Injury Prevention Data Tables/DOH Website.

Note: These are injury rates per 100,000 population.

* denotes rates not calculated for values < 5

Review of South Central Region trauma death and injury statistics for 1998 to 2002, are listed in the table above. Statistics continue to show that motor vehicle crashes are the leading cause of unintentional death within the Region. Falls, especially in the elderly, are the leading cause of unintentional injury and hospitalization within the Region. This trend has been consistent over the years.

The South Central Region EMS and Trauma Council has tried several models to provide injury prevention and public education. The Region now has joined with the successful SAFE KIDS coalitions in Walla Walla/Columbia, Benton/Franklin, Yakima and Kittitas Counties to collaboratively approach injury prevention needs. The Council provides funds to the coalitions so they can continue to provide a wide variety of injury prevention and public education programs. The Coalitions have programs that address the major categories of injury and death identified by Washington State Vital Statistics above. They have well-established programs such as passenger, pedestrian, bicycle safety, drowning, poisoning and burn prevention programs.

The Regional Council provides injury prevention and public education grants of \$33,000.00 to the SAFE KIDS coalitions, and in return the SAFE KIDS Coalitions fulfill the Regional injury prevention and public education goals as established by the Regional Council.

The South Central Region created a unique injury prevention program to help make children more visible during low light times. The program is called the “Wildfeet” program and consists of small retro-reflective four toed feet that can be applied to items such as bikes and backpacks. The program utilizes scrap retro reflective material donated by the Department of Transportation sign shop in Union Gap. Currently, inmates from the Yakima County Department of Corrections use the Regions press to produce Wildfeet packets.

Recognizing the large numbers of injuries and deaths due to falls, especially in the elderly, the Regional Council asked the SAFE KIDS Coalitions to expand their existing programs to include elderly fall prevention programs. The SAFE KIDS Coalitions have programs such as “Safety at Grandma’s House” and “Tread to Safety” that include fall prevention information. The Coalitions are working with other organizations in their areas to create a list of organizations providing fall prevention information that will be available by September 2005.

Local statistics show that impaired drivers cause 42 % of Motor Vehicle Crashes (MVCs) within the Region. The Regional Council has a partnership with the Walla Walla, Benton, Franklin, and Kittitas County DUI Taskforces. The Regional Council provides the avenue for pass-through State and Federal grant funds to the DUI Taskforces.

The Regional Council has an active Prevention Committee that meets regularly. This Committee reviews the SAFE KIDS Coalition work plans and reports Coalition activities at the Regional Council meetings. Many Regional Council members participate in and support injury prevention and public education activities in their local areas and within the Region.

2. Need Statement

There is a need to increase public awareness of injury prevention activities through programs and activities that will reduce the number of deaths and injuries related to MVCs, the leading cause of death in the Region.

There is a need to continue funding for car seat check sites, car seats for distribution to low-income families, and bike helmet programs. National SAFE KIDS program is cutting financial support to the local SAFE KIDS Coalitions for many programs including car seat and bike helmet funding.

There is a need to increase public awareness through programs and activities that educate on the cause and prevention of falls, especially in the elderly, the second leading cause of injury in the South Central Region. It is through education that death and injury due to falls can be decreased.

There is a need to increase public awareness through programs and activities that will educate on the dangers of unintentional poisoning, the third leading cause of death in the South Central Region. It is through education that deaths and injuries due to poisoning can be reduced.

There is a need to increase public awareness through programs and activities to educate the public on drowning prevention issues in an attempt to decrease drowning or near drowning, the fourth leading cause of death in the South Central Region.

There is a need to provide injury prevention information to the non-English speaking populations within the Region. The Region has a large Spanish speaking population as well as an influx of Russian and Asian populations. More injury prevention information is needed in several languages.

Based on Regional statistics, there is a need to provide suicide prevention information to the public.

All of the Regional SAFE KIDS programs would benefit from more staff to coordinate and expand their programs.

3. Goals



Goal 1: Death and injury are decreased in the top four categories of MVC, falls, poisoning, and drowning.

Objective 1: Increase public awareness through programs and activities that will provide education on the four major causes of injuries and deaths within the Region by providing annual funding to SAFE KIDS coalitions to carry out planned injury prevention activities each year.

Strategy 1: Allocate annual funding from Regional Council budget to the SAFE KIDS coalitions in Kittitas, Yakima, Benton/Franklin and Walla Walla/Columbia Counties to support Injury Prevention Public Education programs that address activities that put the public at risk in the South Central Region.

Objective 2: Work with SAFE KIDS coalitions to ensure Regional injury prevention goals are addressed and progress is reported to the Regional Council at bimonthly meetings.

Strategy 1: Each SAFE KIDS coalition will provide the Regional Council an annual work plan and budget for planned activities. They will provide monthly activity reports and an annual report at the end of the year.

Strategy 2: The Regional SAFE KIDS Coalitions during the year will provide 80 safety and injury prevention messages and information on upcoming events throughout the Region to local newspapers and media. Copies of newspaper articles are to be provided in each coalition's monthly report.

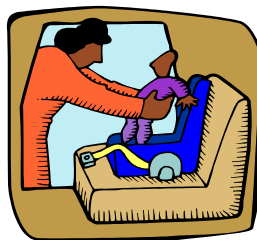
Costs

System Costs

System costs are currently unavailable

Regional Council Cost: The Regional Council provides a \$33,000 grant each year that is divided among the four SAFE KIDS Coalitions to support meeting the Regional injury prevention public education goals. Each Coalition receives the following: Kittitas County, \$4,950; Yakima County, \$9,900; Benton/Franklin Counties, \$9,900; and Walla Walla/Columbia Counties, \$8,250. If funds were available, many more injury prevention and public education programs and activities could be available within the Region.

Barriers: There is always an ongoing need for more funding and volunteers for injury prevention and public education activities. All injury prevention programs need more paid staff to coordinate and expand their programs.



Goal 2: The use of child safety restraints throughout the region results in fewer MVC deaths and injury due to unrestrained children.

Objective 1: Conduct 80 car seat clinics annually within the Region that increase and promote the correct use of child restraint devices.

Strategy 1: Provide free or low cost car seats to at risk low-income families who cannot afford to purchase them, at least once a month at a car seat clinic in each area.

Strategy 2: Each coalition will track and report the number of car seat clinics and seats checked, numbers of car and booster seats distributed, and the numbers of Child Passenger Safety Technicians trained during the year in their monthly or annual reports to the Regional Council.

Objective 2: Facilitate 6 Child Passenger Safety Technician training courses through the biennium.

Strategy 1: Provide three annual Child Passenger Safety Technician courses throughout the Region.

Cost

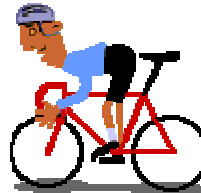
System Costs

The SAFE KIDS Coalitions estimate the cost of a Car Seat Technician Training Class at least \$2,400.00. Each coalition puts on one or more training classes per year for a minimal estimated cost of \$9,600.00 for four classes. They also estimate the costs of car and booster seats, to be over \$21,000 per year at an estimate of 100 to 150 seats a year per coalition.

Regional Council Costs:

This program is part of the regular SAFE KIDS Coalition programs and individual costs are not factored out.

Barriers: There is an ongoing need for to purchase car and booster seats and for more volunteers to man the check stations.



Goal 3: Increased helmet usage throughout the Region to decrease serious head injury.

Objective 1: Facilitate 50 events where Safety Helmet Use & Safety Education information is distributed annually throughout the Region.

Strategy 1: Each SAFE KIDS Coalition will distribute Safe Helmet Use and Safety Education information at combined safety events. In addition, each coalition will annually facilitate two bike rodeos or other event that focuses on safety helmet use and education.

Strategy 2: Each SAFE KIDS coalition will provide a monthly reports and an annual report of the number of children/adults provided with educational materials, the number of helmets distributed, and the number of helmets distributed at safety events.

Costs

System Costs

The Regional Council does not have cost information on region-wide bicycle safety and head injury prevention and public education programs. The four SAFE KIDS Coalitions estimate just purchasing helmets for their programs is in excess of \$8,000 per year.

Regional Council Cost:

This program is part of the regular SAFE KIDS Coalition programs and individual costs are not factored out.

Barriers: There is a need for funding to purchase helmets and to increase the number of volunteers to man the helmet fit stations and participate in the Regional bike rodeos.



Goal 4: Increased visibility of children/pedestrians during low light time by use of “Wildfeet” stickers.

Objective 1: Increase public awareness and provide retro reflective Wildfeet stickers to make children more visible during low light times at 50 safety events annually throughout the region.

Strategy 1: The Prevention Committee will provide reports to Regional Council at their meetings.

Costs

System Costs

In 1992, the Regional Council facilitated a statewide “Wildfeet” program at a cost well over \$100,000.00. There is not enough scrap retro-reflective material from the Union Gap Department of Transportation (DOT) sign shop to support a statewide program, however, the Regional Council has maintained the Wildfeet program as a Regional program.

Regional Council Cost:

The retro-reflective material is scrap donated by DOT Sign Shop in Union Gap and Yakima County Department of Correction jail inmates provide the labor using the Regional press. Occasionally the press needs repair and small bags are purchased for the Wildfeet stickers for an annual cost of about \$100.00.

Barriers: No barriers at this time.



Goal 5: Increase public awareness through activities and programs to prevent falls, especially in the elderly.

Objective1: Facilitate 20 fall awareness programs throughout the Region during the biennium.

Strategy 1: Each SAFE KIDS Coalition will include programs such as *Visiting Grandmother’s House, Tread to Safety* and *Remember When*

Strategy 1: Each coalition will provide the number and attendance information for fall prevention programs in their monthly or annual reports.

Objective 2: Develop a list of all fall prevention programs especially for the elderly by May 2007 and make the list available on the regional web site and in hard copy.

Strategy 1: Have a functional Regional Web Page with information and links to SAFE KIDS activities by 2007.

Costs

System Costs

The Regional Council does not have information on the cost of comprehensive Region-wide falls prevention and public education programs.

Regional Council Cost: This program is included in each SAFE KIDS Coalition regular programs. Currently, individual cost of a falls program is not factored out.

Barriers: Lack of volunteers to facilitate the programs.



Goal 6: Increased public awareness activities to protect children from unintentional poisoning.
Objective 1: The SAFE KIDS Coalitions will provide at least 4 poisoning prevention programs during Poisoning Prevention Week each year.

Strategy 1: Each of the four coalitions will report the number attending each program during Poisoning Prevention Week.

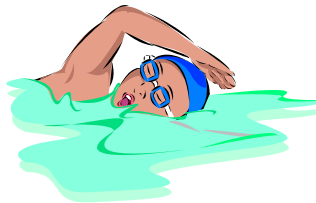
Costs

System Costs

System costs are currently unavailable for comprehensive Region-wide poison prevention and public education programs.

Regional Council Cost: This program is part of the regular SAFE KIDS Coalition programs and individual costs are not factored out.

Barriers: As with all injury prevention programs, there is a lack of funding and volunteers for this program.



Goal 7: Increased public awareness of activities designed to reduce drowning deaths and near drowning injuries.

Objective 1: Support ten drowning prevention events that reduce the risk of drowning for kids and adults by 2006.

Strategy 1: Annually facilitate ten drowning prevention programs such as the “Kids Don’t Float” program within the Region.

Strategy 2: Continue to work with partnering organizations to maintain and provide personal floatation devices for the established Drowning Prevention Boards located at the Kids Fishing Ponds in Columbia Park and at the Richland Fire Department in Benton County, at Sacajawea State Park in Franklin County, at Yakima Fire Station #10 in Yakima, at Vantage State Park in Kittitas County, and at Hood, Fishhook, and Charboneau State Parks in Walla Walla County.

Strategy 3: Monitor the number of PFDs that need replacement each year.

Strategy 4: Seek partners to provide funds for new Drowning Boards and to help determine locations for the new boards.

Strategy 5: Continue to work with Columbia Basin Dive Rescue, Corps of Engineers and other coalition members, to provide drowning prevention education and activities.

Costs

System Costs

System costs are currently unavailable for comprehensive Region-wide drowning prevention and public education programs. However, the estimated cost of each drowning prevention board is

\$1,000.00 including construction, PFDs and site installation. The SAFE KIDS Coalitions are monitoring the number of PFDs that must be replaced on the existing boards each year.

Regional Council Costs:

This program is part of the regular SAFE KIDS Coalition programs and individual costs are not factored out.

Barriers: Drowning board locations and project development issues and funds for the purchase of additional Drowning Boards and PFDs.

Goal 8: IPPE messages in other languages in addition to English are available in the Region.

Objective 1: Provide injury prevention and public education information to both seasonal and resident Spanish speaking populations and report distribution of materials as provided to targeted groups by May 2007.

Strategy 1: The Coalitions will continue to adapt materials for various languages as the need is presented.

Strategy 2: Work with Yakama Indian Health Services to provide information and programs such as safety fairs and bike rodeos for the reservation schools and at events such as Treaty Days and Pow Wows.

Costs

System Costs

System costs are currently unavailable for comprehensive Region-wide injury prevention and public education programs for different ethnic backgrounds.

Regional Council Cost: This program is part of the regular SAFE KIDS Coalition programs and individual costs are not factored out.

Barrier: Lack of interpreters to translate the information into other languages.

Goal 9: Information about the new National Suicide Prevention Lifeline Number 1-800-273-TALK is available in the Region.

Objective 1: Distribute new Suicide Hotline Number information at three Regional Council meetings and provide the information to each SAFE KIDS coalition

Strategy 1: Regional Council members can take copies of the National Suicide Hotline information for distribution at their respective locations.

Objective 2: Identify other organizations with suicide prevention information and activities by May 2006. .

Strategy 1: Compile and distribute a list of organizations within the Region that have suicide prevention programs.

Cost

System Costs

System costs are currently unavailable for comprehensive Region-wide suicide prevention and public education programs.

Regional Council Costs

The cost of distributing the Suicide Prevention Lifeline Number at Regional Council meetings for members to reproduce and distribute is minimal. The Regional Council does not have an estimate of the cost for distribution of lists of organizations with suicide prevention programs.

Barriers

The Regional Council and the SAFE KIDS Coalitions do not know what barriers exist, since this is a new project.



IV. Pre-Hospital

A. Communication

1. System Status

Table B. EMD Training for Emergency Dispatcher Centers by County

| County Name | Total # of Dispatchers in the County | EMD Training Program/s used in the County (if none indicate so) | # Dispatchers within the county who have completed EMD training from a course in column #3 |
|---------------------------------------|--------------------------------------|--|--|
| Benton County | | | |
| Southeast Communication Center | 28 | Criteria Based Dispatch (CBD) | 23 |
| Prosser Police | 7 | None | 0 |
| Columbia County | | | |
| Columbia Co. Sheriff Dept | 7 | Priority Dispatch | 5 |
| Franklin County | | | |
| Franklin Co. Sheriff Dept. | 12 | Criteria Based Dispatch (CBD) | 11 |
| Kittitas County | | | |
| KittCom | 13 | Medical Priority | 13 |
| Walla Walla County | | | |
| Dept. of Public Safety Communications | 15 | Criteria Based Dispatch (CBD) moving to NAEMD in 2005 | 12 |
| Yakima County | | | |
| Yakima Upper Co. | 11 | Criteria Based Dispatch (CBD) moving to Medical Priority in 2005 | 11 |
| Yakima Lower Co. | 9 | None | 0 |
| Region Totals | 102 | | 75 |

EMS & Trauma System communication is critical to a functional Regional Trauma System. Communication system improvements are complicated and require interagency collaboration and a great deal of money. Technological enhancements, including communication towers and state-of-the-art equipment for EMS and Trauma Services and dispatch centers, are ongoing system requirements.

Regional communications systems are based on the VHF HEAR radio system. This technology is outdated and badly in need of updating. There are a couple of areas that utilize 800 MHz. Many EMS agencies use cell phones to contact the trauma services. By using cell phones, patient confidentiality is more likely to be preserved and additional sensitive information can be provided to the receiving trauma service.

The Region has eight emergency dispatch centers ranging from sophisticated E 911 systems to small law enforcement dispatch centers. Emergency Medical Dispatcher (EMD) training has been an identified need for years. Currently, six emergency dispatch centers have trained EMD dispatchers that provide pre-arrival instruction, considered the standard in emergency dispatch circles. Ongoing EMD training continues as a need coupled with training dispatchers for the two centers lacking EMD training. The following table provides information on the emergency dispatch centers, their training programs and the number of EMD trained dispatchers within the Region:

Current relationship between existing Regional communication resources and the following:

- Effective 911/E911 access, including by wireless technology:
Four of the eight dispatch centers already have programs to recognize wireless and have the technology to provide location information. Two dispatch centers are in the process of installing equipment and software and two others centers have active plans to move to wireless technology in 2005.
- Dispatch of EMS by trained emergency medical dispatchers:
The Region recognizes that EMD trained dispatchers are crucial to any EMS and Trauma System. Six of the eight dispatch centers have active programs that train dispatchers in recognized emergency medical dispatch programs and use EMD Dispatchers to dispatch EMS agencies. The Regional Council encourages training of all dispatchers in EMD criteria. The Regional Council has no authority over emergency dispatch centers or resources to provide training for these centers.
- Bystander care with trained emergency medical dispatcher assistance: Pre-arrival instructions are routinely provided by six of the eight dispatch centers.
- Ability within the Region to track average time to contact a live person at 911 centers: Three centers do not have Computer Aided Dispatching (CAD) systems that can provide this information. Several of the centers state they have policies that do not allow calls to be put through to voice mail systems. All centers indicate it is seldom that a call is not answered in a matter of seconds.
- Ability within the Region to track the time from initial 911 call to the dispatch of the responding EMS agency:
The five dispatch centers with CAD systems can track this information. One of the smaller centers states they routinely collect this information so it is available.
- Overload of dispatch centers:
The five dispatch centers with CAD systems report that they can track this information. All reporting dispatch centers claimed that “overload” of the system seldom happens.
- Estimation of costs of state-of-the-art communication technology equipment for EMS communications within the Region is outside the scope of the Regional Council to estimate these costs.
- Ability of EMS agencies to communicate with dispatch, between units, across the region, and with receiving hospitals for on-line medical direction:
Areas where emergency communications have been identified as problematic are in Franklin County Trauma Area #2 and #3 and in Yakima County Trauma Area #1.i and #1.k. In Franklin County a communication tower is being installed and in Yakima County a repeater is being installed during 2005 that will improve communications in those areas.
- Yakima County Trauma Area #2 communication towers or repeaters continue to be needed to improve emergency communications.
- All dispatch centers reported that EMS agencies use cell phones for on-line medical direction. There are several reasons EMS use cell phones, including patient confidentiality issues.

2. Need Statement

There is a need for two dispatch centers to move to wireless technology in 2005 and to provide EMD training for their dispatchers, so that pre-arrival instructions can be provided to the caller.

There is a need for three dispatch centers to move to a CAD system that can track the average time to contact a live person at 911 centers and the time from initial 911 call to the dispatch of the responding EMS agency. One smaller dispatch center hand calculates this time, but needs to move to a CAD system.

All Regional emergency dispatch centers share a common issue, the high attrition rate of emergency dispatchers. Most dispatch centers are finding it necessary to provide EMD training for newly hired dispatchers about every six months.

3. Goals

Goal 1: Enhanced day to day and disaster communication capabilities between emergency dispatch, EMS vehicles, hospitals, and between EMS agencies and other responding entities.

Objective 1: The following areas have been identified as areas where new equipment and technology would greatly enhance the Regional emergency medical communication systems:

- In 2005, a new tower will be installed in North Franklin County in the Kahlotus area. This tower will improve emergency communications for Franklin County FD #2 ambulance in Kahlotus and Franklin County Public Hospital District #1 Ambulances in North Franklin County.
- In 2005, a new repeater will be installed that will improve emergency communications for Yakima FD #3 Aid Service in Naches and Yakima FD #14 on Chinook Pass.
- A continued need is for a new communication tower in Yakima County FD #5 area on the Yakama Reservation to improve emergency communications to its many stations.

Strategy 1: Distribute information on EMS “needs grants” and other communication grants to EMS agencies in the Region as they are made available to the Regional Council office.

Strategy 2: Support and participate in Regional or statewide communications projects as requested.

Cost

System Cost

System costs are currently unavailable for comprehensive EMS & Trauma communication systems. Due to the highly technical nature of this issue, the Regional Council would rely on the state to provide this information.

Regional Council Cost: The Regional Council has no funds to expend toward communication needs within the Region.

Barriers: Fixing communication problems is very expensive and out of the range of either Local or Regional EMS & Trauma Care Councils. In some areas, new communication towers and the land to locate towers would be required. Both EMS responders and trauma services need to have new equipment to improve EMS communications.

Goal 2: All emergency medical calls are handled by trained Emergency Medical Dispatchers who provided appropriate pre-arrival instructions from simple first aid to life saving instructions.

Objective: Identify existing and potential dispatch centers that have EMD trained staff or are in the process of training staff by November 2006.

Strategy: Forward to the Emergency Dispatch Centers any EMD training information that comes through the Regional Council office.

Cost

System Cost

System costs are currently unavailable for EMD training for all dispatch centers within the Region. Regional Dispatch Centers are encouraged to utilize E 9-1-1 funds for Emergency Medical Dispatch training.

Regional Council Costs: The Regional Council has no funds available for EMD training.

Barrier: All Regional emergency dispatch centers share a common weakness, the high attrition rate of emergency dispatchers. Most dispatch centers are finding it necessary to provide EMD training for newly hired dispatchers about every six months.

B. Medical Direction of Prehospital Providers

1. System Status

DOH appoints a physician in each county to provide medical direction for prehospital personnel. WAC 246-976-920 provides authority and direction for the Medical Program Directors (MPDs.) EMS personnel work under the license as well as the direction of the County MPDs.

The Region has five County MPDs that are recognized as leaders in local EMS activities. All MPDs have written patient care protocols that describe and regulate the scope of practice for EMS personnel and medical treatment for all patients. MPDs review, revise and update their protocols on a regular basis. MPDs work closely with local EMS & Trauma Care Councils to develop recommendations for Regional Patient Care Procedures (PCPs), the foundation for local patient care protocols and County Operating Procedures (COPs). COPs are developed when MPDs and local EMS & Trauma Care Councils determine that more direction is needed as to how Regional PCPs will be used throughout their county. Benton/Franklin, Walla Walla, Yakima and Kittitas Counties have COPs.

Although MPDs participate regularly in local EMS & Trauma Care Council meetings, they seldom attend or actively participate in Regional Council meetings. The Regional Council office sends Regional Council meeting and committee meeting minutes to all five County MPDs to assure that they are informed of Regional Council activities and have the opportunity for input into Regional PCPs and Trauma System Plan update. Historically, MPD input is funneled through local council participation.

2. Need Statement

There is a need to increase the stipend paid to the MPDs by DOH. The amount they receive does not cover the amount of time and energy each MPD invests each month in EMS supervision. This need is clearly out of the jurisdiction of the Regional Council. DOH is in the process of providing additional grants to MPDs.

There is a need to keep the MPDs informed of Regional activities. The Regional Council provides MPDs with Regional Council meeting and committee meeting minutes. The Regional Council has a place on the bimonthly Regional Council agenda for MPD reports. MPDs are encouraged to participate at all levels of Regional Council business. Historically, MPDs have participated very little at the Regional Council level. It should be noted that MPDs do participate at the local council level and all Regional MPDs attended the State MPD meetings.

3. Goals

Goal 1: MPD awareness of Regional Council activities.

Objective 1: Continue to encourage MPD participation in Regional Council, development of trauma plan and updates of Regional Patient Care Procedures with quarterly communications during the biennium.

Strategy 1: Work through the County EMS Directors to provide pertinent Regional information to the MPDs and continue to provide MPDs with all Regional Council mailings including Council minutes and committee announcements, drafts of all PCPs and trauma plan updates.

Strategy 2: Allocate agenda time at Regional Council meetings for MPD comments or input.

Cost

System Cost

MPDs contract directly with DOH; they receive a stipend of \$4,800.00 per year. For the five MPDs in the South Central Region there would be a system cost of \$24,000.00.

Regional Council Cost

The Regional Council allocates no funds toward MPD compensation.

Barrier

Barriers to MPDs participation in Regional Council activities include financial and time limitations. The MPDs believe that their participation in the local EMS & Trauma councils is sufficient.

C. Prehospital EMS and Trauma Verified Services

1. System Status

Table C. Prehospital Providers by County, Level, Career & Volunteer

| County | FY 02-03 FR | FY 02-03 EMT | FY 02-03 EMT-I | FY 02-03 PM | FY 04-05 FR | FY 04-05 EMT | FY 04-05 EMT I | FY 04-05 PM |
|------------------------|----------------|-----------------|-------------------|----------------|----------------|-----------------|-------------------|----------------|
| Benton | 87 | 287 | 8 | 54 | 79 | 335 | 11 | 92 |
| Career | 12 | 168 | 2 | 54 | 9 | 183 | 4 | 91 |
| Volunteer | 75 | 119 | 6 | 0 | 70 | 152 | 7 | 1 |
| Columbia | 11 | 23 | 0 | 0 | 10 | 32 | 0 | 0 |
| Career | 1 | 3 | 0 | 0 | 0 | 2 | 0 | 0 |
| Volunteer | 10 | 20 | 0 | 0 | 10 | 30 | 0 | 0 |
| Franklin | 14 | 113 | 4 | 16 | 13 | 108 | 4 | 17 |
| Career | 0 | 32 | 1 | 13 | 0 | 33 | 1 | 15 |
| Volunteer | 14 | 81 | 3 | 3 | 13 | 75 | 3 | 2 |
| Kittitas | 15 | 83 | 0 | 14 | 23 | 102 | 0 | 15 |
| Career | 2 | 15 | 0 | 13 | 2 | 24 | 0 | 14 |
| Volunteer | 21 | 68 | 0 | 1 | 21 | 78 | 0 | 1 |
| Walla Walla | 30 | 135 | 0 | 22 | 20 | 153 | 0 | 26 |
| Career | 1 | 35 | 0 | 22 | 1 | 36 | 0 | 26 |
| Volunteer | 29 | 100 | 0 | 0 | 19 | 136 | 0 | 0 |
| Yakima | 73 | 436 | 14 | 52 | 75 | 456 | 17 | 43 |
| Career | 7 | 150 | 8 | 52 | 6 | 163 | 11 | 50 |
| Volunteer | 66 | 286 | 6 | 0 | 69 | 293 | 6 | 0 |
| Regional Totals | 220 | 1079 | 26 | 180 | 220 | 1203 | 32 | 200 |
| Career | 23 | 403 | 11 | 175 | 18 | 441 | 16 | 196 |
| Volunteer | 215 | 676 | 15 | 5 | 202 | 762 | 16 | 4 |

Total EMS Providers FY 02-03 = 1523

Total EMS Providers FY 04-05 = 1655

The number of EMS providers has increased by 32 individuals from FY 02-03 to FY 04-05

The South Central Region has a mixed network of prehospital EMS services within the Region. The mix includes both career (paid) and volunteer providers. The long response, long transport times, and large rural and wilderness areas in the Region have always made timely EMS response a major goal. The Regional Council advocates a three-tiered EMS response of first responders, BLS ambulance followed by an ILS/ALS ambulance.

While the Regional system is integrated and functional, there is always a concern about possible decrease in EMS volunteers. Over 60% of the South Central Region's EMS personnel are volunteers. Volunteers are vital to the EMS & Trauma System. The table below provides the break out of career versus volunteer:

At this time the Region has experienced an increase of 32 EMS providers from FY 02-03 to FY 03-04. These numbers do not reflect the First Responders who have moved to EMTs or EMTs who have moved to Paramedic. A poll of the County EMS Directors determined that the number of EMS providers is at a status quo within the Region at this time.

Additional public safety personnel and other groups that augment the EMS and Trauma System

- **Law enforcement** and EMS have always had a partnership. State Patrol, police and sheriff officers are often on scene at an incident prior to the arrival of EMS agencies. The state AED

grant project has further enhanced this partnership. Eligible law enforcement agencies are provided AED equipment and training to use it. They work closely with EMS partners who do the training and data input if the equipment is used. EMS agencies also work closely with local County Search & Rescue organizations for wilderness rescue. Search & Rescue often is an arm of law enforcement.

- **Medical Emergency Helicopter** personnel have become an important partner in Regional EMS operations. They have provided EMS and trauma training as well as assistance in rapid patient transport and wilderness rescue.
- **Affiliated Agencies** are defined in WAC as an agency that is not required to be licensed, but is recognized as a participant in the Regional Trauma System. These agencies include ski patrols, dive rescue organizations, law enforcement, search and rescue organizations, hazardous material teams, private employers and many others. Personnel from affiliated agencies must meet Regional CME and OTEP training requirements for certification and follow the MPD protocols and Region PCPs.

Affiliated agencies have long been recognized as an EMS partner when injury or illness occurs on job sites. These agencies provide patient care on site until regular EMS agencies respond. The following are the Affiliated Agencies within the South Central Region:

Columbia County

Bluewood Ski Patrol
Columbia County Search & Rescue

Benton County

Energy Northwest
Columbia Basin Dive Rescue
Mid-Columbia Pre-Hospital
Care Association

Walla Walla County

Blue Mt. EMS Association
Walla Walla County Sheriff
Walla Walla Police Department
Whitman Mission
Walla Walla Regional Airport
Washington State Patrol
Department of Natural Resources
Public Safety Communications
Walla Walla County Road Dept

Kittitas County

Kittitas County Sheriff
CWU/Paramedic Program
Kittitas County EMS Division
Columbia Basin College

Franklin County

Columbia Basin College

Yakima County

Yakima EMS
Terrace Heights Sewer Dist
Canam Steel Corporation
Yakima Co. Sheriff Search &
Rescue
Grandview Police Dept
Tieton Police Dept
Naches Ranger District
White Pass Ski Patrol
Yakima Training Center FD

Other Agencies Involved In Specific Elements of Trauma System Planning and Development are as follows:

- **Hanford Fire Department** provides ALS ambulances that respond to EMS incidents on the Hanford Nuclear Reservation site and to incidents near the reservation borders.
- **Columbia Basin Dive Rescue (CBDR)** provides emergency water rescue service and assists with water recoveries of drowning victims, criminal evidence, autos, etc, in Benton, Franklin, Walla Walla Counties in Washington State and Umatilla and Morrow Counties in the State of Oregon.
- **The U.S. Army MAST Helicopter Unit from the Yakima Training Center**, when they are available, provides emergency helicopter rescues for remote wilderness incidents in Yakima and Kittitas Counties.
- **The U.S. Army Umatilla Chemical Depot**, a nerve gas storage site located in Oregon State, provides bi-state disaster planning, training, and drills as part of the Chemical Stockpile Emergency Planning Process (CSEPP) plan for destruction of nerve gas.

- **Volpentest Hazardous Materials Management Emergency Response (HAMMER) Training Facility** is a unique training facility located in Richland, that is involved in advanced training for emergency response agencies of all kind.
- **Yakama Native American Reservation**, The South Central Region has one Native American Reservation, the Yakama Indian Nation. This Reservation covers a large portion of Southern Yakima County and has several small towns, vast areas of wilderness with limited access, and high incident of traffic related crashes and fatalities.
- **Educational Institutions** play an important role in Regional Trauma System development by providing EMS and healthcare provider training and education. The following Regional colleges provide EMS and trauma service education:
 Walla Walla Community College, in Walla Walla
 Columbia Basin Community College, in Pasco
 Central Washington University, in Ellensburg

2. Need Statement

Regional needs relating to the prehospital provider workforce

Following the established Regional process of seeking input from the Local EMS & Trauma Care Councils on trauma system updates and needs, the Regional Council asked for input on the following topics and received the following information:

- **Recruitment and retention of EMS providers:**
 Recruitment of EMS providers is coordinated by each local EMS agency. The current survey of recruitment and retention of EMS providers on a Region-wide basis demonstrates and the figures provided by DOH demonstrate that the numbers of EMS personnel is relatively stable. According to statistics, Regional totals have stayed about the same for two years. Most Local EMS & Trauma Care Councils state they have been able to maintain EMS providers at a consistent level except in rural areas with low population and call volume.
- **Initial provider training and continuing education (OTEP)**
 The Regional Council has a long and well-established process of helping to provide training through EMS training and education contracts with the five Local EMS & Trauma Care Councils. Over \$75,000 per year is divided among the local councils for EMS initial training, CME, and OTEP classes. Training funds are divided utilizing a formula based on the number of providers and square miles in each county. Each local council provides the Region with an EMS training work plan and budget on how funds will be expended during the year.

In Walla Walla, Columbia, and Benton/Franklin Counties, the EMS councils partner with the local community colleges to provide First Responder and EMT-B training. In Kittitas and Yakima Counties, the Local EMS & Trauma Care Council provides initial EMS training at intervals throughout the year based on need and/or requests from EMS agencies.

The Regional Council has developed a Regional BLS OTEP course that meets training requirements over a three-year cycle. This course has been made available to all local councils. Kittitas and Yakima Counties have chosen to use other state approved programs for EMS OTEP.

In 2004, the Regional Council developed an ALS OTEP program approved by all five County MPDs. The Regional Council identified the need to purchase a power point projector for each local council, to be dedicated to the ALS OTEP program.

- **Instructor pool**
 There is a need for additional SEI's as reported by all local EMS & Trauma Councils. All Councils report they have individuals in the "process" of becoming SEI's. There is a need for extra funding to offset SEI training requirements. The long involved process of becoming an SEI seems to be a limiting factor for training additional SEI's within the Region.

All councils state they currently have sufficient levels of BLS Evaluators/Instructors. BLS Evaluators/Instructors, however, do need to be replaced from time to time due to retirement, other time commitments and constraints, and attrition. Therefore, BLS Evaluator/Instructor classes are offered periodically throughout the Region. All EMS & Trauma Care Councils stated that they have paramedics, nurses, and physicians that assist with EMS training, CME, and OTEP.

- **Opportunities for skill maintenance**

There is a need for skill maintenance. All Local EMS & Trauma Care Councils provide OTEP programs that include skill maintenance. In agencies with low call volume, skill maintenance is a greater issue. Ambulances in the Region provide ride along programs for EMS training. All County MPDs allow for specific supervised mannequin training. Local EMS & Trauma Care Councils state that agreements are in place with local hospitals to provide experience in such skills as IVs, intubations, and Emergency Department time for training. However, other training courses require ED time sometimes limiting the time available for EMS personnel.

- **Training/education aids and equipment**

All local EMS & Trauma Care Councils report that there is a need for additional funds beyond the EMS training funds provided by the Regional Council, to replace training equipment such as disposable supplies and outdated equipment. In addition there is a need to keep up with the changing technology in state-of-the-art training equipment (DOH definition- the highest level of development of a device, technique, or science currently available.) This new equipment is very costly and out of reach for most Local EMS & Trauma Care Councils who provide Regional EMS training. Local EMS & Trauma Care Councils do not qualify for EMS Needs Grants and are limited in obtaining additional training funds. The Regional Council has no budget specifically designated for training equipment. Only two local EMS Trauma Care Councils, Walla Walla and Yakima Counties, have EMS levies that help offset additional training and equipment costs. The other three councils, Columbia County, Kittitas County and Mid Columbia (Benton and Franklin Counties) find upgrading and replacing EMS training equipment a financial hardship.

Addendum B provides a detailed list of training equipment requested in FY 2005. The Regional Council identified the need for 5 power point projectors to be used for the new ALS OTEP program in each local council area. On a one- time basis, the Regional Council reimbursed each local EMS & Trauma Care Council up to \$1,500 for a power point projector to be dedicated to the ALS OTEP program. However, when the projector is not being used for ALS OTEP programs, it may be utilized for other EMS training.

- **Basic and state-of-the-art emergency medical care equipment**

There is a need for all trauma verified EMS agencies within the South Central Region to continue their EMS responses. In addition, there is a need for *basic EMS equipment for trauma response areas that have been identified as needing new First Responder Aid Services. The Regional Council also identified trauma response areas where existing EMS services need to increase EMS skills and verification levels. Additional EMS equipment could be needed to meet the increased skill and verification levels. Technology in EMS & trauma care changes rapidly creating an ongoing need to update and replace EMS equipment. Replacement of equipment can be a financial hardship, particularly for volunteer agencies.

Addendum B provides a list of EMS equipment listed as needs in FY 2005.

According to information from county emergency management surveys and disaster drills there is a need to update and enhance the EMS & Trauma communication equipment including communication towers, radios for EMS agencies and trauma services, cell phones and satellite cell phones.

3. Goals

Goal 1: Recruitment and retention of EMS providers.

Objective 1: Provide EMS training funds annually to the local EMS & Trauma Councils for OTEP and CME needs identified in annual Local Council EMS Training Work plans.

Strategy 1: Monitor EMS training monthly training reports to assure local training work plans and Regional EMS training goals are being met.

Goal 2: Basic and State of the Art EMS equipment

Objective 1: Work through the local EMS & Trauma Care Councils to support EMS agencies in the process of applying for EMS Needs Grants.

Strategy 1: Regional Council staff or members will provide upon request an opportunity in each county for one-on-one assistance with the EMS Needs Grant application by holding a training session on the same day as the Local Council meetings closest to the needs grant submission date. The Regional Council will provide documentation of the meetings and help given.

Goal 3: SEI Instructors are available for County EMS training.

Objective 1: Local EMS & Trauma Councils will identify an SEI candidate in the FY 2006 work plan with a goal to complete their training by June 2007.

Strategy 1: Progress of SEI candidates will be reported in the monthly training reports as appropriate.

Goal 4: Updated training/education aids and equipment are available in the Region.

Objective 1: Assist eligible EMS Needs Grant participants to complete applications for training/education aids and equipment during the next grant cycle in the biennium through a county help session prior to the application due date and report.

Strategy 1: Regional Council staff or members will provide upon request an opportunity in each county for one-on-one assistance with the EMS Needs Grant application by holding a training session on the same day as the Local Council meetings closest to the needs grant submission date. The Regional Council will provide documentation of the meetings and help given.

Strategy 2: Request that DOH consider accepting EMS Needs Grants from Local EMS & Trauma Councils that facilitate countywide EMS training. The Local EMS & Trauma Care Councils are central training sites for counties within the Region, but are not eligible for EMS Needs Grants for training equipment.

System Cost:

System costs are currently unavailable for comprehensive EMS training, EMS training equipment or EMS equipment throughout the Region. Addendum B lists EMS equipment and EMS training equipment needs submitted to the Regional Council in FY 2004.

The Regional Council does not have the capabilities to provide accurate and realistic costs associated with SEI Instructor training.

Regional Council Cost: The Regional Council provides a total of \$76,000.00 in EMS training grants to the local EMS & Trauma Councils to provide EMS OTEP, CME and initial training each year but no additional funds are available for training equipment. The grants are dispersed using a formula of land area and number of EMS providers. Only two Counties, Yakima and Walla Walla, have EMS levies that assist in offsetting training equipment costs. The other local EMS & Trauma Care Councils have very limited resources to purchase EMS training equipment.

Barriers: EMS agencies have equipment needs they cannot meet especially in the rural volunteer agencies. Only Yakima and Walla Walla Counties have EMS levies to help offset equipment purchase.

An additional barrier is the cost and time involved in training new SEIs.

D. Verified Aid and Ambulance Services:

1. System Status:

Table D. - Approved Min/Max numbers of Verified Trauma Services
By Level and Type by County

| County | Verified Service Type | State Approved - Minimum number | State Approved - Maximum number | Current Status (# Verified for each Service Type) |
|--------------------|-----------------------|---------------------------------|---------------------------------|---|
| Benton | Aid – BLS | 4 | 4 | 2 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 0 | 1 | 0 |
| | Amb – ILS | 0 | 2 | 2 |
| | Amb - ALS | 4 | 5 | 5 |
| Columbia | Aid – BLS | 2 | 3 | 2 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 1 | 1 | 1 |
| | Amb – ILS | 0 | 1 | 0 |
| | Amb - ALS | 0 | 0 | 0 |
| Franklin | Aid – BLS | 1 | 3 | 1 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 2 | 2 | 2 |
| | Amb – ILS | 0 | 1 | 0 |
| | Amb - ALS | 1 | 1 | 1 |
| Kittitas | Aid – BLS | 5 | 10 | 7 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 1 | 3 | 2 |
| | Amb – ILS | 0 | 0 | 0 |
| | Amb - ALS | 2 | 2 | 2 |
| Walla Walla | Aid – BLS | 8 | 8 | 6 |
| | Aid –ILS | 0 | 0 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 1 | 3 | 3 |
| | Amb – ILS | 0 | 1 | 0 |
| | Amb - ALS | 1 | 1 | 1 |
| Yakima | Aid – BLS | 18 | 20 | 18 |
| | Aid –ILS | 0 | 1 | 0 |
| | Aid – ALS | 0 | 0 | 0 |
| | Amb –BLS | 2 | 9 | 0 |
| | Amb – ILS | 0 | 1 | 1 |
| | Amb - ALS | 3 | 3 | 3 |

The Process for Determining Need and Distribution of Trauma Verified EMS Services

The Regional Council partners with its five Local EMS & Trauma Care Councils to recommend minimum and maximum numbers of trauma verified EMS agencies. The Regional Council has a biennial process for seeking updated information and input from the Local EMS and Trauma Councils on all components of the trauma system. For recommendations on changes to the trauma verified minimum maximum numbers, the councils are asked to evaluate EMS needs such as response time, geographic location served, population density, skills maintenance and additional system influences such as tiered response and dispatch protocols and procedures. The Regional and Local Councils have always been very clear about the state mandate to prevent the inefficient duplication of services.

The Regional and Local EMS & Trauma Care Councils identify both existing EMS agencies where EMS skills and trauma verification levels should be increased and areas that are underserved by EMS. In the early planning process, the Regional and Local Councils chose to utilize the established and recognized fire district boundaries to identify specific geographic locations for EMS service areas. Trauma Response areas are identified as the current boundaries of these Fire Districts. It must be understood that the use of these boundaries does not mandate in any way that the fire districts in those areas must deliver EMS care. Continuing barriers to meeting the recommendations for minimum and maximum trauma verified EMS agencies include political climate, lack of human and financial resources, and low EMS call volume that effects skill maintenance.

The South Central Region does not have map-making abilities so asked each local Council area to provide Trauma Response Area Maps. The following are the maps provided to the South Central Region for Trauma Response Areas in each county.

Table E. Trauma Response Areas by County

| Benton County EMS & Trauma Response Area # | Description of Trauma Response Area's Geographic Boundaries | Type and # of Verified Services in each Response Areas |
|---|---|---|
| #1 | Within the current city limits of Kennewick and boundaries of Kennewick Fire Department and Benton County Fire District #1 | A-1 F-1 |
| #1.a | In the city limits of Kennewick | F-1 |
| #1.b | In the boundaries of Benton County FD #1 | A-1 F-1 |
| #2 | Within the current city limits of Richland and West Richland and boundaries of the Richland Fire Department and Benton County Fire District #4. | A-1 F-1 |
| #2.a | Within the city limits of Richland | F-1 |
| #2.b | In the city limits of West Richland and the boundaries of Benton County FD #4 | A-1 F-1 |
| #3 | Within the current boundaries of the Hanford Nuclear Reservation, Highway 24 to intersection of Highway 21, and Highway 240 from mile post 22 to milepost 0. | F-1 |
| #4 | In the current city limits of Benton City and the boundaries of Benton County Fire District #2 | E-1 |
| #5 | Within the current boundaries of Prosser Hospital District, Benton County FD #3, south on Highway 22 to Sellards Road, southwest to Alderdale and Bickleton, on Highway to Bickleton in Yakima County defined as Yakima County FD #7. | F-1 |
| #6 | Within the current city limits of Paterson, the boundaries of Benton County FD #6, north to Sellards Road, east to Payment Road, west to Alderdale Road and Peterson Road. | E-1 |

Key: For each level the type and number should be indicated

Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

Agencies Currently Verified in Benton County Trauma Response Areas:

Kennewick Fire Department, verified ALS Ambulance (career)
Benton County Fire District #1, verified BLS Aid Service (volunteer)
Richland Fire Department, verified ALS Ambulance Service (career)
Benton County Fire District #4, verified BLS Aid Service (career/volunteer)
Hanford Fire Department Ambulance, verified ALS Ambulance Service (career)
Benton County Fire District #2, verified ILS Ambulance (volunteer)
Prosser Hospital Ambulance, verified ALS Ambulance Service (career)
Benton County Fire District #6, verified ILS Ambulance Service (volunteer)
American Medical Response, verified ALS Ambulance (career)

| Columbia County EMS & Trauma Response Area # | Description of Trauma Response Area's Geographic Boundaries | Type and # of Verified Services in each Response Areas |
|---|---|---|
| #1 | Within the boundaries of Columbia County | A-1 D-1 |
| #1.a | With in the city limits of Dayton and the boundaries of Columbia County Fire District #3 | D-1 |
| #1.b | Within the city limits of the town of Starbuck and boundaries of Columbia County Fire District #1 | A-1 D-1 |

Key: For each level the type and number should be indicated

Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

Agencies Currently Verified in Columbia County Trauma Response Areas:

Columbia County Fire District #3 Ambulance, verified BLS Ambulance Service (volunteer)
Columbia County Fire District #1, verified BLS Aid Service (volunteer)

| Franklin County EMS & Trauma Response Area # | Description of Trauma Response Area's Geographic Boundaries | Type and # of Verified Services in each Response Areas |
|---|---|---|
| #1 | Within the current City limits of Pasco, Franklin County FD #3 boundaries, and north to Sagemore Road. | A-1 F-1 |
| #1.a | Within the city limits of the City of Pasco | F-1 |
| #1.b | Within the boundaries of Franklin County FD #3 and north to Sagemore Road. | A-1 F-1 |
| #2 | Within the boundaries of Franklin County Hospital District #1 that includes the communities of Connell, Mesa, Basin City and Merrill's Corner, west to the Columbia River and south to Sagemore Road. | D-1 |
| #3 | Within the current city limits of Kahlotus and the boundaries of Franklin County Fire District #2 | D-1 |

Key: For each level the type and number should be indicated

Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

Agencies Currently Verified in Franklin County Trauma Response Areas:

Pasco Ambulance, verified ALS Ambulance Service (career)
Franklin County Fire District #3, verified BLS Aid Service (volunteer)
Franklin County Public Hospital District #1, verified BLS Ambulance Service (volunteer)
Franklin County Fire District #2, verified BLS Ambulance Service (volunteer)
American Medical Response, verified ALS Ambulance (career)

| Kittitas County EMS & Trauma Response Area # | Description of Trauma Response Area's Geographic Boundaries | Type and # of Verified Services in each Response Areas |
|---|--|---|
| #1 | Within the current boundaries of Kittitas County Public Hospital District #1 (which includes the cities of Ellensburg and Kittitas, the rural communities of Vantage and Thorp, and FD#1, FD#2, and FD#4) | A-3 D-1 F-1 |
| #1.a | Within the current boundaries of the City of Ellensburg | F-1 |
| #1.b | Within the current city limits of Kittitas and surrounding areas of FD#2. | D-1 F-1 |
| #1.c | Within the current boundaries of Kittitas County Fire District #1 (which includes the rural community of Thorp) | A-1 F-1 |
| #1.d | Within the current boundaries of Kittitas County Fire District #2 | A-1 D-1 F-1 |
| #1.e | Within the current boundaries of Kittitas County Fire District #4 (which includes the rural community of Vantage) | A-1 F-1 |
| #2 | Within the current boundaries of Kittitas County Public Hospital District #2 (which includes the Cities of Cle Elum and Roslyn, Town of S. Cle Elum, the rural community of Ronald and Snoqualmie Pass, and FD#3, FD#6, FD#7, and FD#8) | A-5 D-2 F-1 |
| #2a | Within the current city limits of Cle Elum | A-1 D-1 F-1 |
| #2.b | Within the current city limits of Roslyn | A-1 F-1 |
| #2.c | Within the current city limits of the Town of S. Cle Elum | A-1 D-1 F-1 |
| #2.d | Within the current boundaries of Kittitas County Fire District #3 (which includes the rural community of Easton and surrounding rural and wilderness areas) | A-1 D-1 F-1 |
| #2.e | Service area northwest of Cle Elum bordering KCFD#7 and KCFD#3 boundaries, including Ronald and Lake Cle Elum residential and recreational areas encompassed in KCFD#6 but not limited to KCFD#6 boundaries. The response area extends east and north to the KCHD#2 boundary, and west along Lake Kachess. | D-1 F-1 |
| #2.f | Within the current boundaries of Kittitas County Fire District #7 (which includes the areas of Upper Peoh Point, West Nelson Siding, Airport, Teanaway, and Highway 97 to the Blewit Pass Summit. | A-1 D-1 F-1 |
| #2.g | With in the current boundaries of Kittitas County Fire District #8 (which includes the community of Lake Kachess) | A-1 D-1 F-1 |
| #2.i | Within the joint service areas of Kittitas County FD #5 and King County FD #51 in the Snoqualmie Pass area. | D-1 F-1 |

Key: For each level the type and number should be indicated

Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

Agencies Currently Verified in Kittitas County Trauma Response Areas:

Ellensburg Fire Department, verified ALS Ambulance (career)
Kittitas Fire Department, verified BLS Ambulance/Aid (volunteer)
Kittitas County Fire District #1, verified BLS Aid Service (volunteer)
Kittitas County Fire District #2, verified BLS Aid Service (career/volunteer)
Kittitas County Fire District #4, verified BLS Aid Service (volunteer)
Kittitas County Hospital District #2, verified ALS Ambulance (career)
Cle Elum Fire Department, verified BLS Ambulance/Aid Service (volunteer)
Roslyn Fire Department, licensed BLS Aid Service (volunteer)
S. Cle Elum Fire Department, verified BLS Aid Service (volunteer)
Kittitas County Fire District #3, verified BLS Aid Service (volunteer)
Kittitas County Hospital District #2, Lake Cle Elum Volunteer program
Kittitas County Fire District #7, verified BLS Aid Service (volunteer)
Kittitas County Fire District #8, verified BLS Aid Service (volunteer)
Kittitas County FD #5 with King County FD #51 Ambulance/Aid Service (volunteer)

| Walla Walla County EMS & Trauma Response Area # | Description of Trauma Response Area's Geographic Boundaries | Type and # of Verified Services in Each Response Area |
|--|--|--|
| #1 | Within the boundaries of Walla Walla County | A-7 D-2 F-1 |
| #1.a | Within the City limits of Walla Walla | D-1 F-1 |
| #1.b | Within the current boundaries of Walla Walla County Fire District #4 and a portion of Department of Natural Resources land in the Blue Mountains. | D-1 F-1 |
| #1.c | Within the city limits of the City of College Place | A-1 F-1 |
| #1.d | Within the current city limits of the town of Dixie and the boundaries of Walla Walla County Fire District #8 including the Department of Natural Resources lands in the Blue Mountains. | A-1 F-1 |
| #1.e | Within the city limits of the town of Prescott and the boundaries of Walla Walla County Fire District #7 | A-1 F-1 |
| #1.f | Within the current boundaries of Walla Walla County Fire District #2, includes the City of Waitsburg | In process A-1 D-1 F-1 |
| #1g | Within the current city limits of the town of Waitsburg and the combined boundaries of Walla Walla Fire District #2 and Columbia County Fire District #2 | D-1 F-1 |
| #1.h | Within the current boundaries of Walla Walla County Fire District #3 that includes Vista Hermosa and Broetje Orchards | A-1 D-1 F-2 |
| #1.i | Within the current boundaries of Walla Walla County Fire District #1 that includes Lower Monumental Dam | A-1 F-1 |

| Walla Walla County EMS & Trauma Response Area # | Description of Trauma Response Area's Geographic Boundaries | Type and # of Verified Services in Each Response Area |
|--|--|--|
| #1.j | Within the current boundaries of Walla Walla County Fire District #5, including the towns of Burbank, Walulla and to the Wallula Junction of Highway 12 and 730 & Ice Harbor Dam | D-1 |
| #1.k | Within the current boundaries of Walla Walla County Fire District #6, includes the Stateline Windmill Project | A-1 F-1 |

Key: For each level the type and number should be indicated

Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

Agencies Currently Verified in Walla Walla County Trauma Response Areas:

Walla Walla Fire Department, verified ALS Ambulance (career)
Walla Walla County Fire District #4 verified BLS Ambulance (volunteer)
Collage Place Fire Department, verified BLS Aid Service (volunteer)
Walla Walla Fire District #8, verified BLS Aid Service (volunteer)
Walla Walla Fire District #7, verified BLS Aid Service (volunteer)
Walla Walla Fire District #2, verified BLS Aid Service (volunteer)
Walla Walla Fire District #7, verified BLS Aid Service (volunteer)
Waitsburg Ambulance, verified BLS Ambulance Service (career/volunteer)
Walla Walla Fire District #3, verified BLS Aid Service (volunteer)
Walla Walla Fire District #1, verified BLS Aid Service (volunteer)
Walla Walla Fire District #5, verified BLS Ambulance Service (volunteer)
Walla Walla Fire District #6, verified BLS Aid Service (volunteer)

| Yakima County EMS & Trauma Response Area # | Description of Trauma Response Area's Geographic Boundaries | Type and # of Verified Services in each Response Areas |
|---|---|---|
| #1 | The Upper Yakima Valley | A-11 F-2 |
| #1.a | In the City of Yakima and the surrounding rural areas | A-1 F-2 |
| #1.b | In the City of Union Gap and surrounding rural areas | A-1 F-2 |
| #1.c | In the City of Selah and the boundaries of Yakima FD #2 | A-1 F-2 |
| #1.d | In the towns of Moxee and Terrace Heights and the boundaries of Yakima FD #4 | A-1 F-2 |
| #1.e | In the town of Gleeed and the boundaries of Yakima FD #6 | A-1 F-2 |
| #1.f | In the communities of West Valley and Tampico and the boundaries of Yakima FD #12 | A-1 F-2 |
| #1.g | In the town of Tieton and surrounding rural/wilderness area | A-1 F-2 |
| #1.h | In the town of Cowiche and the boundaries of Yakima FD #1 | A-1 F-2 |
| #1.i | In the town of Naches and the boundaries of Yakima FD #3 | A-1 F-2 |

| Yakima County EMS & Trauma Response Area # | Description of Trauma Response Area's Geographic Boundaries | Type and # of Verified Services in each Response Areas |
|---|--|---|
| #1.j | In the community of Naches Heights and the boundaries of Yakima FD #9 | A-1 F-2 |
| #1.k | In the communities of Nile Valley and Cliffdale and boundaries of Yakima FD #14 | A-1 F-2 |
| #2 | The lower Yakima Valley including the Yakama Reservation, Highway 97 and Highway I-82 to the town of Granger | A-5 E-1 F1 |
| #2.a | The city limits of the town of Zillah and the boundaries of Zillah City Fire and Rescue | A-1 F-1 |
| #2.b | In the city limits of the town of White Swan and Yakama Reservation | A-1 E-1 F-1 |
| #2.c | The city limits of the town of Wapato and the boundaries of the Wapato Fire Department | A-1 F-1 |
| #2.d | The city of limits of the town of Toppenish and the boundaries of the Toppenish Fire Department | A-1 F-1 |
| #2.e | In the city limits of the town of Granger and the boundaries of the Granger Fire Department | A-1 F-1 |
| #3 | The southern part of the Lower Yakima Valley, including the City of Sunnyside, the boundaries of the Sunnyside Fire Department, north on Highway 241 to the Silver Dollar Café, south to Green Valley Road, east to Countyline Road, and west to Beam Road. | A-1 F-1 |
| #4 | The city limits of the town of Mabton and boundaries of the Mabton Fire Department; the city limits of the town of Grandview and the boundaries of the Grandview Fire Department; and between the towns of Mabton and Bickleton in the boundaries of <i>Yakima County Fire District #7</i> ; | A-2 F-1 |

Key: For each level the type and number should be indicated

| | |
|-------------|-------------------|
| Aid-BLS = A | Ambulance-BLS = D |
| Aid-ILS = B | Ambulance-ILS = E |
| Aid-ALS = C | Ambulance-ALS = F |

Agencies Currently Verified in Yakima County Trauma Response Areas:

American Medical Response, verified ALS Ambulance (career)
Advanced Life Systems, verified ALS Ambulance (career)
Yakima Fire Department, verified BLS Aid Service (career)
Union Gap Fire Department, verified BLS Aid Service (career/volunteer)
Yakima Fire District #2, verified BLS Aid Service (volunteer)
Yakima County Fire District #4, verified BLS Aid Service (volunteer)
Yakima Fire District #6, verified BLS Aid Service (volunteer)
Yakima Fire District #12, verified BLS Aid Service (career/volunteer)
Tieton Fire Department, verified BLS Aid Service (volunteer)
Yakima Fire District #1, verified BLS Aid Service (volunteer)
Yakima County Fire District #3, verified BLS Aid Service (volunteer)
Yakima County Fire District #9, verified BLS Aid Service (volunteer)
Yakima County Fire District #14, verified BLS Aid Service (volunteer)
Yakima County Fire District #5, verified BLS Aid Service (career/volunteer)
Zillah City Fire and Rescue, verified BLS Aid Service (volunteer)
White Swan Ambulance, verified ILS Ambulance Service (volunteer)

Wapato Fire Department, verified BLS Aid Service
Toppenish Fire Department, verified BLS Aid Service
American Medical Response, verified ALS Ambulance Service (career)
Granger Fire Department, verified ALS Ambulance Service (volunteer)
Sunnyside Fire Department, verified ALS Ambulance Service (career/volunteer)
Mabton Fire Department, verified BLS Aid Service (volunteer)
Grandview Fire Department, verified BLS Aid Service (volunteer)
Prosser Memorial Hospital ALS Ambulance Service (career)

Refer to South Central Region Trauma Response Area maps Addendum C.

2. Need Statement:

There is a need to continue to provide the established tiered EMS system within the Region. This is a system of BLS trauma verified aid services that respond with BLS/ILS/ALS trauma verified ambulances services. Agreements have been established in areas where ALS rendezvous with BLS or ILS ambulances are needed. In the past year, the Region has experienced economic and political changes that effect ALS rendezvous with BLS/ILS ambulances. An ALS ambulance has refused to rendezvous outside of its defined trauma response area. The Regional Council will closely monitor these changes and how they affect the Regional Trauma System.

There is a need to continue to identify underserved areas that do not have access to even the minimum or BLS aid service. In other identified areas there is a need for EMS skills levels and trauma verification levels to be increased. In the early 1990's system assessment analysis process the Regional Council identified numerous areas in which additional service was needed. Over the years many of the needed services have been put in place. The following are still unmet needs and continue to be a focus of the Regional and Local Councils in building the best possible system:

Benton County needs for EMS Trauma Verified Services

1. A BLS Trauma Verified Ambulance Service in Benton County Trauma Response Area # 2.b.
2. Trauma verified BLS Aid Service in the rural western portion of Benton County in Trauma Response Areas #5 and #6.

Columbia County need for EMS Trauma Verified Services

1. In Columbia County Trauma Response Area #1.a, the Council has recognized a need for an ILS/ALS Trauma Verified Ambulance Service for many years.
2. In Columbia County Trauma Response Area #1, in the combined department boundaries of Columbia County Fire District #2 and Walla Walla County Fire District #2, there is a need for a Trauma Verified Aid Service.
3. In Columbia County Trauma Response Area #1.a, there is a need for a trauma verified BLS Aid unit in the Tucannon Recreational Area, located in the eastern portion of Columbia County. Increased EMS responses and acuity of EMS responses justify this need.

Franklin County need for EMS Trauma Verified Services

1. In Franklin County Trauma Response Area #2 there is a need to increase EMS skill levels to ILS/ALS Trauma Verified Ambulance.
2. In Franklin County Trauma Response #3 there is a need for a trauma verified ILS ambulance service. (The BLS ambulance in this area has been struggling to maintain a BLS trauma verified ambulance status).
3. In Franklin County Trauma Response Areas #2 and #3 there is a need for trauma Verified BLS Aid Services to do a tiered response with the BLS Trauma Verified Ambulances.

Kittitas County need for EMS Trauma Verified Services

In Kittitas County Trauma Response Area # 2.f, there is a need for an additional BLS Trauma Verified Aid Service in the area of Blewitt Pass.

Walla Walla County need for EMS Trauma Verified Services

1. In Walla Walla County Trauma Response Area #g, there is a need for a BLS Trauma Verified Aid Service.
2. In Walla Walla County Trauma Response Area #1.j, there is a need for an ILS Trauma Verified Ambulance Service.

Yakima County need for EMS Trauma Verified Services

1. In Yakima County Trauma Response Areas #1.h, #1.i, #1.f, #1.k and #2, there is a need for BLS Trauma Verified Ambulance Services.
2. In Yakima County Trauma Response Area #2, there is a need for at least one ILS Trauma Verified Aid unit.
3. In Yakima County Trauma Response Area #4, between the towns of Mabton and Bickleton as defined by the boundaries of Yakima County Fire District #7, there is a need for a BLS Trauma Verified Aid Service.

3. Goals

Goal 1: Trauma Verified EMS Services are available at the appropriate level in all areas of the Regional system.

Objective 1: Local EMS & Trauma Councils will identify the need for EMS services or advances in EMS services and report progress or lack of progress toward meeting those needs in their annual Training & Education work plan.

Strategy 1: List the needs and goals identified by the local councils in the South Central Region EMS & Trauma System Plan.

Objective 2: The plan review committee will Review the local EMS & Trauma System status, needs and goals biennially or more often as needed for inclusion and update of the EMS & Trauma System Plan update and revision.

Strategy 1: The Trauma Plan Review Committee asks that each local council evaluate their EMS needs and goals in September 2007 during the EMS & Trauma System Plan update.

Cost

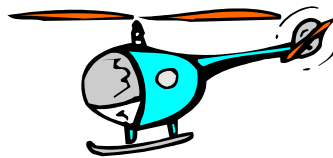
System Cost

System costs are currently unavailable for establishing EMS agencies or increasing skill levels and equipment to meet the increased skill levels.

Regional Council Costs

The Regional Council provides \$76,000 annually to the local EMS & Trauma Care Councils for EMS training that includes First Responder, EMT-B and ILS training. No other Regional funds are designated for increasing levels of EMS care.

Barriers: Economics and low population are barriers to EMS provider recruitment attempts and establishing new EMS services in underserved areas.



Air Ambulance Services

The Regional Council recognized early in trauma system development that emergency medical helicopter ambulance scene response would greatly enhance EMS and trauma care within the Region. A centrally located emergency medical helicopter ambulance would help to reduce long response and transport times. In January 2003 the goal for emergency medical helicopter service was recognized with a service located at the Pasco Airport. When the U.S. Army MAST Helicopter is available at the Yakima Training Center, they provide emergency wilderness rescue.

Currently, there are no ALS interfacility fixed wing transport air ambulance services located in the South Central Region. Fixed wing transport must respond to the Region from Seattle, Spokane, or Wenatchee.

DOH is in the process of developing a statewide air ambulance plan. The following are the Air Ambulance Resources in the Region:

Northwest MedStar provides a trauma verified ALS emergency medical helicopter service based at the Pasco Airport. The helicopter has the capacity to carry two patients. The service is available to do scene responses within the southern part of the South Central Region as well as interfacility transports. Northwest MedStar also has a trauma verified emergency medical helicopter service based at the Moses Lake Airport, which is located just north of the South Central Region. This emergency medical helicopter often has a shorter response time to areas in the northern part of the Region. Northwest MedStar provides a fixed wing interfacility transport air ambulance service from the Spokane Airport that responds to the South Central Region.

Airlift Northwest provides ALS air ambulance helicopter scene response from the Seattle area to Kittitas County and interfacility fixed wing air ambulance service from both Seattle and Wenatchee.

U.S. Army MAST Helicopter Unit from the Yakima Training Center provides emergency helicopter wilderness rescue for the Region when they are available.

E. Patient Care Procedures (PCPs)

PCPs are defined in WAC as “written operating guidelines adopted by regional councils in consultation with local EMS & trauma care councils, MPDs, and emergency dispatch centers.” Regional PCPs are the foundation for county operating procedures (COPS) and the broad base for local patient care protocols. County MPD protocols cannot be in conflict with Regional PCPs. Local COPS have been submitted with the Regional PCPs for DOH review.

1. System Status:

Regional Patient Care Procedures (PCPs) have been established in the South Central Region EMS & Trauma Care System for many years. PCPs are re-evaluated at least every two years as part of the Trauma System Plan update. This review is accomplished by sending the current PCP's out to each Local Council and MPD and soliciting input for updates or modifications. The Regional Council reviews the information from the Local Councils and assigns needed work to the Regional Council PCP Committee. The Regional Council approves PCPs biennials for inclusion in the Regional EMS and Trauma Care Plan. Regional PCPs have been implemented by all EMS agencies in all counties. Updates are provided to the Emergency Dispatch Centers. The emergency dispatch centers have no obligation to follow Regional PCPs but they do utilize PCP # 1, "Dispatch." The Regional Council has developed and put into place the following PCPs to provide direction and guidance for trauma system implementation:

- Patient Care Procedure # 1 - Dispatch
- Patient Care Procedure # 2 - Response Times
- Patient Care Procedure # 3 - Triage And Transport
- Patient Care Procedure # 4 - Interfacility Transfer
- Patient Care Procedure # 5 - Medical Command at Scene
- Patient Care Procedure # 6 - EMS/Medical Control Communications
- Patient Care Procedure # 7 - Helicopter Alert and Response
- Patient Care Procedure # 8 - Diversion
- Patient Care Procedure # 9 - BLS/ILS Ambulance Rendezvous with ALS Ambulance
- Patient Care Procedure #10 - Trauma System Data Collection
- Patient Care Procedure #11 - Routine EMS Response Outside of Recognized Service Coverage Area
- Patient Care Procedure #12 - Emergency Preparedness/ Special Responders

County Operating Procedures (COPS) have been developed in Kittitas, Yakima, Benton/Franklin and Walla Walla Counties to provide more specific local direction as to how EMS providers will utilize the Regional PCPs.

Both the Regional PCPs and local COPS provide an organized approach to care of trauma and medical patients in the field. Through the State Trauma Triage Tool, Regional PCPs, and COPS, EMS agencies know where to transport both trauma and medical patients. Through PCP # 9 Rendezvous, BLS and ILS agencies have prearranged agreements and process to rendezvous with ALS agencies as needed.

With the advent of an emergency medical helicopter in the South Central Region, three local councils have revised County Operating Procedures to further define utilizing this service. Those county COPS are attached with the Regional PCPs.

2. Need Statement

There is a continued need for Regional PCPs and COPS to be reviewed at least every two years in the Trauma System Plan review process. In spite of sending PCP's to Local Councils and MPDs there have not been recommendations for changes and no system issues have been identified.

There is a need to develop a Regional PCP on Burn Care as part of the Bioterrorism planning process.

3. Goals

Goal 1: Patient Care Procedures and County Operating Procedures meet the needs for excellent patient care in the South Central Region.

Objective 1: Regional PCP Committee will review all Regional Patient Care Procedures at least every two years or more often as needed. The review will be completed by October 2006.

Strategy 1: The Regional Council will work with MPDs and Local Councils during 2005 to identify an approach that will ensure their input on PCP development and review by the 2006 Regional Plan development process and will report progress.

Objective 2: The Regional Council will develop a PCP to address Burn Care Due to Acts of Terrorism within the South Central Region by May 2006.

Strategy 1: The Regional Council will utilize data collected from the State-wide Burn Capacity Survey to develop a Regional Burn Care PCP as soon as the information is available.

Strategy 2: The Regional Council PCP Committee will seek input from local EMS & Trauma Council and other planning bodies including the Public Health Region 8 Hospital Bioterrorism Committee and the South Central Regional All Hazards Committee to develop the Burn Care PCP.

Strategy 3: The Regional Council will seek DOH approval prior to implementing new PCPs

Objective 3: Local EMS & Trauma Care Councils will develop and continue to update local COPS every two years or more often as needed. Review will be completed by October 2006.

Strategy 1: The Regional Council will provide technical assistance as requested to the local councils for COP development and ensure county COPS are consistent with Regional PCPs.

Cost

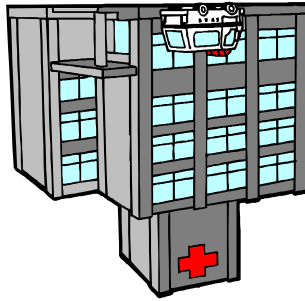
System Cost

The Regional Council does not have information on the cost of the time for MPDs, local EMS & Trauma Care Councils and Regional Council members donate toward developing PCPs and COPS.

Regional Council Costs

No specific Regional funds are allocated toward PCP development.

Barrier: MPDs provide input to the local EMS & Trauma Care Councils but lack time and incentive to participate at the Regional Council level for PCP development.



V. Designated Trauma Care Services

A. Trauma Services

1. System Status

Trauma Services in the South Central Region are integral parts of the EMS and Trauma Care System. They provide definitive initial and prolonged care for trauma patients. Their readiness and resources are vital. The comprehensive EMS and Trauma Care System in the Region includes the designation of nine hospitals as General Acute Trauma Services, two pediatric Level III Trauma Services and three Level II Trauma Rehabilitation centers. Since designation is an elective procedure, health care facilities make a commitment and determine the level of trauma service designation that they will seek. Each facility uses a team approach with a trauma team activation plan, trauma education, trauma registry data submission, and an ongoing continuous quality improvement (CQI) program.

The South Central Regional Council has recommended to DOH the number, level and location of designated trauma, pediatric trauma and trauma rehabilitation services. Designation recommendations were based on an analysis of population data, number of patients meeting trauma criteria, locations of health care facilities, existing EMS transport patterns, estimated EMS transport times and surgical and medical resources available at each facility. Regional analysis showed a broad spectrum of trauma care and medical staff capabilities, ranging from small rural clinics and hospitals with limited medical resources, to large medical centers with sophisticated trauma care equipment and medical specialties. As with EMS resources, higher-level trauma designation and trauma care resources are available in suburban/urban areas.

The Regional Council made the following recommendations:

- Level II designated General Acute Trauma Services, Level III Pediatric Trauma Services and Level II Trauma Rehabilitation Services located in the following cities:
 - Yakima,
 - Tri Cities (Richland, Kennewick, Pasco),
 - Walla Walla.
- Level III Designated General Acute Trauma Services in the following cities:
 - Ellensburg,
 - Sunnyside
 - Toppenish.
- In the town of Dayton, the Regional Council recommended a Level IV Designated General Acute Trauma Service, however, the resources of the hospital there allows for a designated Level V General Acute Trauma Service designation.
- In the town of Cle Elum, the Regional Council recommends a Level V Designated General Acute Trauma Service. The Kittitas County PHD #2 Emergency Medical Clinic that held that designation has been closed for a number of years. Since there is a continued need for a Designated Level V Trauma Service, the Regional Council will continue to support the efforts of the EMS, medical community and the citizens committee in their efforts to once again establish a designated trauma service in that area.

The most common reason the trauma services designated at lower than recommended levels is the lack of physicians in medical specialties such as neurosurgical, surgical and orthopedic.

The Regional Council reviewed its recommendations for designated trauma services in 2004 and continues to advocate three Level II Trauma Services. The justification for this recommendation is based on the long distances and transport times between health care facilities.

The Regional Council continues to support and recommend the Level III, IV and V designation levels as recommended in this and previous EMS & Trauma Plans. Most hospitals have designated below the designation levels recommended by the Regional Council. The Region requested and DOH approved an increase of one Level III trauma service in the Tri Cities area in November 2004.

All Regional designated Trauma Rehabilitation Services have designated at the levels recommended by the Regional Council, and in the locations recommended for rehabilitation services.

Table F. Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Services (General Acute Trauma Services)

| Level | State Approved | | Current Status |
|-------|----------------|-----|----------------|
| | Min | Max | |
| II | 3 | 3 | 0 |
| III | 3 | 4 | 4 |
| IV | 2 | 2 | 4 |
| V | 1 | 2 | 1 |
| II P | 0 | 1 | 0 |
| III P | 3 | 3 | 2 |

Current Designated Trauma Care Services:

Kittitas Valley Community Hospital – Level IV General Acute Trauma Service
 Yakima Trauma Service (Yakima Valley Memorial and Yakima Regional) – Level III General Acute & Level III Pediatric Trauma Service
 Toppenish Community Hospital – Level IV General Acute Trauma Service
 Sunnyside Community Hospital – Level IV General Acute Trauma Service
 Prosser Memorial Hospital – Level IV General Acute Trauma Service
 Tri Cities Trauma Service (Kadlec Medical Center, Kennewick General Hospital, Lourdes Medical Center) – Level III General Acute Trauma Service
 St. Mary Medical Center – Level III General Acute Care & Level III Pediatric Trauma Service
 Walla Walla General Hospital – Level III General Acute Trauma Service
 Dayton General Hospital – Level V General Acute Trauma Service

Table G. Approved Minimum/Maximum (Min/Max) numbers of Designated Rehabilitation Trauma Care Services

| Level | State Approved | | Current Status |
|-------|----------------|-----|----------------|
| | Min | Max | |
| II | 3 | 3 | 3 |
| III* | | | |

**There are no restrictions on the number of Level III Rehab Services*

Current Designated Rehabilitation Trauma Care Services

Yakima Regional – Level II Trauma Rehabilitation Service
 Tri Cities Rehabilitation Trauma Service (Kadlec Medical Center and Lourdes Medical Center) – Level II Trauma Rehabilitation Service
 St. Mary Medical Center – Level II Trauma Rehabilitation Service

2. Needs Statement

Based on the original recommendations on the number and level of trauma services, there is still a need for trauma services to designate at Trauma Designated Levels recommended by the Regional Council. Analysis of Registry Data and patient outcomes, show there is a continued need for more neurosurgeons in the Region. Presently, neurosurgical coverage is not available 24/7 at any of the three hospitals that offer this specialized care. EMS Medical Control in each city keeps track of where neurosurgery is available so they can provide direction to EMS services. The Tri Cities Trauma Service and St. Mary Medical Center have established a ring-down telephone system that they use daily to check on the availability of neurosurgery in their facilities. Trauma services are actively attempting to recruit neurosurgeons, general surgeons and orthopedic surgeons.

Hospitals in the South Central Region report that there is a need for additional hospital personnel ranging from nursing to ancillary services. The shortage of hospital staff is a Region, State and National problem. Schools of nursing in Yakima, Pasco, and Walla Walla graduate new nurses every year, however, many new nurses leave the Region for more urban population centers where pay is higher and more specialized positions are available. Several health care facilities within the Region utilize “traveling nurse and ancillary services” to make up for the shortage of staff. Use of these services increases health care cost for facilities.

There is a need for health care facilities, especially rural hospitals, to attempt to stay up on the ever-changing realm of medical care. Facilities are eliminating services and adopting critical access models that decrease bed capacity. How these changes will affect the Regional Trauma System remains to be seen.

3. Goals

Goal 1: Trauma Services are designated at the recommended number and levels in the South Central Region.

Objective 1: The Regional Council will continue to encourage the efforts of trauma services that designated lower than Regional recommendations to increase their designation levels.

Strategy 1: Provide Regional and State Registry data analysis of population data, numbers of trauma patients, and existing EMS transport patterns to trauma services who are considering a higher level of designation as requested.

Cost

System Cost

System costs are currently unavailable for trauma services to increase levels of designation. The cost of physician recruitment is well beyond the scope of the Regional Council.

Regional Council Cost

The Regional Council does not allocate Regional Council funds for this category.

Barriers: Trauma Services face both cost and political barriers when considering increasing trauma service designation levels.



VI. EMS and Trauma System Evaluation

A. Information Management

1. Regional System Status

The Regional Council has long recognized that Trauma data is crucial to future EMS and trauma system planning and implementation. Data provides information for evaluation of the evolving South Central Region EMS and trauma system. WAC 246-976-430 directs *designated* trauma services to collect trauma data for the state Trauma Registry for both EMS and Trauma Services.

Washington EMS Information System

The Department of Health has a grant to develop a new EMS Information System Program. The Regional Council will support this evolving DOH program as requested. The Regional Council will continue to encourage local EMS agencies to participate in WEMIS.

Status of EMS Data Collection by EMS Agencies

The Regional Council has supported and provided information to the Washington EMS Information System project. The Regional Council office surveyed the EMS agencies in the Region to ascertain their method of EMS data collection and software vendors. Sixty agencies responded to the survey. It was determined that in Kittitas and Walla Walla Counties, the County EMS Directors submit EMS data for the small volunteer rural agencies. Forty-seven agencies reported that they use a form of software for collecting EMS data.

Status of EMS Run Times from Dispatch Centers

The Regional Council polled the emergency dispatch centers on the collection of EMS run times in 2004. Five of the Regional emergency dispatch centers reported that run time information is collected through their CAD system. Of the three remaining centers, one reported that they routinely track this information by hand.

Timely Submission of Prehospital Trauma Data to Trauma Services

A few Regional Trauma Services in 2004 reported through the CQI Committee that there are a few EMS transporting agencies that do not routinely leave a copy of their run sheet at the hospital at the end of transport. Individual trauma services worked with their local EMS agencies and the county MPD to assure that all trauma EMS data is collected in a timely manner.

2. System Need Statement

There is a need for three Regional Emergency Dispatch Centers who not have CAD systems to establish a method for collecting dispatch and EMS run times.

It is a DOH requirement that trauma services to submit quarterly Trauma data. Each trauma service works with its local EMS transport agencies to collect and report trauma data from EMS run reports.

3. Goal

Goal 1: Timely accurate and complete data collection and submission for use by the regional CQI Committee.

Objective 1: The Region will support Prehospital data collection efforts.

Strategy 1: The Regional Council will host a WEMIS workshop in 2005.

Objective 2: The Region will support hospital trauma data collection efforts

Strategy: Host Trauma Registry and Coding Trainings as needed.

Goal 2: Data is used by the Regional Council to assess and analyze Regional EMS and Trauma System needs.

Objective: The Regional Council will use data to develop and modify the Regional EMS & Trauma Plan during the planning process.

Strategy 1: Request trauma registry and other relevant data from DOH.

Strategy 2: Request reports as appropriate from the regional QI program on identified regional system issues.

Cost

System Cost

System costs are currently unavailable for CAD Systems for Emergency Dispatch Centers who do not have them now. The cost of additional personnel needed for submission of data for dispatch centers, EMS agencies or trauma services is also unknown.

Regional Council Cost

There are no Regional funds available to address the data collection issues.

Barrier: Lack of appropriate equipment and personnel to collect and input EMS and trauma system data.

B. Quality Assurance

1. System Status

WAC authorizes and defines the EMS and Trauma System Evaluation process (CQI Plan). The Regional CQI Plan has been developed by the Regional trauma services. The regional CQI Plan has a goal of timely analysis of trauma system trends, coupled with actual trauma patient care issues.

The regional CQI Committee is comprised of representatives from each of the Regional trauma services, prehospital providers and EMS coordinators. The Committee meets three or four times a year. Currently, the Committee reviews aggregate data from DOH. The Committee does case reviews that demonstrate how the trauma system is working, or not working. Regional Council staff and Regional Council members attend the CQI Committee meetings and provide information as requested.

Prehospital Agency QA

Prehospital EMS CQI has at least two tiers:

1. Agency level CQI on EMS runs is the responsibility of each agency within the Region.
2. Although, each County MPD has a CQI process that includes regular meetings with EMS providers and case review, the MPDs have no obligation to provide CQI information or results to the regional CQI Committee or the Regional Council.

MPD Role in Prehospital QI/QA

MPDs review and analyze EMS run sheets. When issues are identified, they arrange for counseling and additional training as needed.

MPD are regularly notified and invited to regional CQI meetings. They occasionally attend, primarily if they have an issue or if the meeting is in their city. They do not regularly provide input to the CQI process.

EMS & Trauma CQI

The regional CQI Committee is the review Committee for trauma care evaluation. The Committee is concentrated review on transfers within the Region and outside the Region with emphasis on neurosurgical evaluation and outcomes. The CQI Committee also reviews unexpected trauma survivals and unexpected trauma deaths, air ambulance transports and EMS transport issues.

The CQI Committee has membership that includes representatives from the trauma services, Prehospital, dispatch centers, and the Regional Council. Physician attendance is minimal at the CQI Committee meetings. The Committee is working to improve this issue through the trauma coordinators.

The CQI Committee identified the lack of neurosurgery coverage within the Region. There are three geographic areas in the Region, the City of Yakima, the Tri Cities, and the City of Walla Walla, where neurosurgical coverage is available part of the time. The committee formulated a plan to utilize the already established daily ring down phone system established at the three Tri Cities hospitals and include St. Mary Medical Center in Walla Walla and the Yakima Trauma Service. Each day the trauma services would report who has neurosurgical coverage. St. Mary has established the phone system and participates in the daily ring down system. The CQI Committee is developing a guideline that includes criteria for appropriate transfer of neurosurgical patients to outlying services. It is anticipated that Yakima Trauma Service will join the daily ring down system when a guideline is in place.

The goal has always been for Regional CQI data to be used by the Regional Council for changing and improving the Regional Trauma System Plan. It has been difficult to establish the feedback loop of the CQI process.

2. Need Statement:

There is a need for timely collection and submission of complete trauma system data to enable comprehensive system review of trauma care at prehospital and hospital levels.

1. There is a need for all trauma services to have representation at the CQI Committee meetings.
2. There is a need for neurosurgical care daily throughout the Region. There is a need for the Yakima Trauma Service to participate in the ring down phone system reporting daily neurosurgical coverage.
3. There is a need to establish a process for information exchange between the regional CQI Committee and the Regional Council to show how the trauma system is working on all levels.

3. Goal

Goal 1: Timely accurate and complete data collection and submission for use by the regional CQI Committee.

Objective 1: The CQI Committee will analyze trauma registry data and monitor trends at their meetings three or four times a year.

Strategy 1: As appropriate, the regional CQI Committee will provide a non- confidential aggregated report to the Regional Council on trauma system findings.

Strategy 2: The Regional Council will utilize information from the regional CQI Committee during the update planning process for the Regional EMS & Trauma Plan.

Cost

System Cost

The cost of wages and time for trauma service staff, physicians, EMS providers, emergency dispatch center personnel and other parties to be involved in trauma system CQI meetings is currently not available. The cost of neurosurgeon recruitment is also unknown.

Regional Council Cost

The Regional Council has no funds to allocate for regional CQI activities.

Barrier

The regional CQI process is problematic due to lack of participation by trauma services representatives, trauma service medical directors, MPDs, and members of the regional CQI Committee.



VII. All Hazards Preparedness (Natural, Manmade & Terrorist/Weapons of Mass Destruction [WMD])

A. Prehospital Preparedness

1. Regional System Status

All hazards preparedness is a national, state, and local issue.

Disaster planning and preparedness is the responsibility of each county's Emergency Management Office. All Counties have Disaster Plans that incorporate natural and man made events and involve all level of providers including EMS and trauma services. These County Disaster Plans are tested regularly on at least an annual basis.

With the advent of Bioterrorism (terrorist and weapons of mass destruction) preparedness, the Federal Government assigned Public Health Agencies as the lead agencies. State and local Public Health agencies have been bringing together all the agencies and entities involved in disaster planning. In the State of Washington, eight Public Health Regions have been identified. All agencies and entities already involved in disaster planning are now involved in planning for terrorist events as well as natural and manmade disasters (All Hazards Preparedness.)

The eight Public Health Regions identified in the State of Washington do not have the same county configuration as the eight EMS & Trauma Care Regions. EMS & Trauma Systems have established response, transport, and transfer relationships for EMS agencies and trauma services that have been disrupted through the Bioterrorism Regions configurations. Additional confusion occurs because there is a lack of knowledge of EMS resources available in counties that have not been part of the "EMS & Trauma System Regions" planning process.

The South Central Region is working to establish communication lines with county Emergency Operation Centers and the Region 8 Homeland Security planning group. These entities have the responsibility and authority to provide EMS equipment within Region 8. EMS equipment comes to the EOCs from grants through the Office of Domestic Preparedness, ODP. The EOCs are under no obligation to provide the Regional Council with information concerning EMS equipment needs or distribution of equipment. Region 8 Homeland Security reports that most EMS equipment provided by ODP grants have not been for individual EMS agencies but to large projects such as hazardous response teams, Benton County Bomb Squad and other "broad" equipment placements. Therefore, the Regional Council finds providing accurate information about placement of EMS equipment in Region 8 problematic. No agency is responsible for collecting information on WMD training. Each individual agency is to track that information. The Federal government has stated that all disciplines involved in homeland security will have to adopt NEMIS training in FY 2006 to be eligible for CDC or ODP grants.

- **Level of Collaboration**

The South Central Region has established collaborative working relations with Public Health Region 8, County Emergency Operation Centers, and Region 8 Trauma Services to develop a Hospital Bioterrorism Plan. The South Central Region's role is to support Public Health, the lead agency in all hazards preparedness.

Collaborative efforts with county EOCs and EMS agencies are not as defined at this time. Each county EOC must have a disaster plan that includes EMS as a component. Bioterrorism planning is being embedded in the existing county disaster plans so there is no requirement to develop separate Bioterrorism plans.

The South Central Region has well established working relationships with County EMS directors and with County MPDs. The Regional Council also has established lines of communication with EMS agencies and EMS providers within the South Central Region. Disaster and all hazards planning is clearly the responsibility of the county EOC managers, who work with the administrators of fire and EMS agencies for disaster and all hazards planning.

- **Drills**

Public Health Region 8 facilitated a tabletop Bioterrorism drill in 2003. The South Central Region, county public health agencies, county officials, county EOCs, fire departments, law enforcement agencies, EMS agencies, hospitals, and everyone else who has a role in emergency preparedness were invited to participate.

A functional drill was held in 2004, to test the abilities of the county EOCs, public health and Region 8 trauma services to respond to a continuation of the Bioterrorism drill from the previous year. The critique of that drill is not yet available.

- **Regional Council's Role**

The Regional Council has a support role through its DOH Contract for all hazards preparedness. The first part of the contract is for the Regional Council to assist Public Health Region 8 in Hospital Bioterrorism planning. The Hospital Bioterrorism plan developed in 2003, written by the administrator of the South Central Region, is being updated by the Public Health and Region joint contractor in 2005. The Regional Council was responsible for collecting the hospital based negative pressure isolation capacity surveys from each hospital and forwarded them to DOH.

The Regional Council will work with DOH and Public Health to collect Burn Care Capacity Survey information from both hospitals and EMS. The information from the Burn Care Capacity Surveys will be used to guide development of a Regional Patient Care Procedure to provide trauma and burn care to 50 severely injured adult and pediatric patients due to a mass casualty.

The second part of the Regional Council's contract is to work with public health, Region 8 hospitals, EMS agencies, and DOH to facilitate developing a mutual aid plan for upgrading and deploying EMS units in jurisdictions they do not normally cover in response to a mass casualty incident due to terrorism. The Regional Council has appointed an All Hazards Committee to help facilitate this part of the contract. The Regional Council and the All Hazards Committee will be assisting DOH in addressing Mutual Aid Agreements and Memorandums of Understanding, emergency response plans, and triage and transport plans for 500 adult and pediatric patients.

- **Status of WMD Preparedness**

The status of EMS WMD preparedness is continually changing as more information, equipment and training is made available through the county EOCs.

Prehospital WMD Equipment

The County EOCs are responsible for the distribution of EMS equipment made available through ODP grants. The County EOCs are not required to provide information to the Regional Council. The Regional Council therefore is not capable of providing an accurate report on the status of WMD equipment to EMS agencies.

Prehospital WMD Awareness Training

EOC's have offered WMD awareness training in a number of locations across the region. WMD training is available on a website at <http://training.fema.gov/emiweb/IS/is700.asp>. This website training is available to EMS providers, hospital staff, and any others who need WMD training. This online training will enable staff to obtain training in a timely process without having to travel. At this time agencies are to maintain their own records. The Regional Council is not capable of providing an accurate report of WMD training needs or training accomplished within Region 8.

Mutual Aid Agreements

County EOCs have compiled lists of mutual aid agreements among EMS agencies and many other disciplines that are involved in a large-scale disaster/Bioterrorism (All Hazards) events. Mutual Aid Agreement information is available and located at Yakima County, Klickitat County, Benton County, Franklin County, and Walla Walla County Emergency Operation Centers. The South Central Region provided DOH with a list of existing Mutual Aid Agreements obtained from the county EOCs in 2004.

The Regional All Hazards Committee investigated developing a Region 8 Mutual Aid Agreement. A great deal of input was provided by the fire department based EMS agencies concerning additional regional mutual aid agreements. The fire departments strongly recommended that the existing State Fire Mobilization Plan be utilized as the Region 8 mutual aid agreement. The Committee is working on a process for inclusion of the eight EMS agencies in Region 8 that are not part of a fire department and not included in fire mobilization.

• Interoperability

Interoperability of EMS Equipment Resources

The individual Counties are working on improving the interoperability between emergency responders. Until this barrier is resolved at the county level it cannot be addressed at the Regional level.

The information current available to the South Central Region on the status of interoperability includes the following:

Each county EOC maintains up-to-date lists of all kinds of equipment resources available in each county including EMS equipment. The compatibility of EMS equipment from one agency to another is not clearly defined. Responsibility for this element and tracking lies with the County EOCs is not readily available to the Region Council.

The All Hazards Committee identified the basic need for EMS agencies to utilize compatible IV tubing that is used by receiving hospitals. The patient incurs additional cost and time is lost when IV tubing must be changed when the patient enters the emergency department. The All Hazards Committee will be working with the Region 8 Hospital Bioterrorism Committee to determine if compatible could be utilized across Region 8.

Interoperability of EMS Communications across the region and on-line medical direction

Communication equipment interoperability continues to be a primary issue in Region 8 and the South Central Region. It is critical for emergency dispatch centers, EMS agencies, trauma services, County EOCs, public health and other emergency responders to be able to communicate with each other. All but two EMS agencies use the HEAR radio for primary communications with hospitals. The City of Kennewick and the City of Richland Fire Departments use 800 MHz for primary communications. Cell phones are also utilized by most EMS agencies to contact trauma services when sensitive information needs to be communicated. EMS agencies cannot communicate directly with local law enforcement or

other responding emergency providers and must rely on emergency dispatch centers to be the go between.

The hospitals cannot communicate with each other using the HEAR system so at present must depend on telephone communications. The HEAR system and associated radio equipment are outdated and becoming obsolete. An emergency situation in the state demonstrated that fax and Internet communications could be used successfully in emergency situations. These modes are not currently available in the field, but can be used by hospitals to communicate with each other. The whole gambit of the emergency communications system is of great concern.

Benton and Franklin Counties are purchasing and establishing mobile command centers that can be used during disaster situations. Franklin County is also purchasing and installing a radio tower in north Franklin County that will greatly enhance radio communications for Franklin County FD #2 and Franklin PHD #1 BLS ambulances. This area was one identified by the Regional Council where emergency communications were difficult or next to impossible. The communication tower will also be utilized by the Franklin Sheriff Department.

The EMS agencies in Public Health Region 8 obtain their on-line medical control through their local trauma services. It is critical that EMS be able to communicate with the trauma services. In the event that on-line communications are not possible, all County MPDs have developed off-line protocols that direct emergency care of patients. The MPDs statewide elected to honor each other's protocols in the event EMS agencies from outside their area respond into the county.

DOH has established a new state communications position. The South Central Region and Public Health Region 8 will work with the new DOH communication person to assist in identifying continuing needs related to interoperability of equipment, communications and patient processes.

Interoperability of WMD patient care procedures/protocols/guidelines

DOH is in the process of developing several surveys for EMS and hospitals that will provide the regions with important information that will be used to develop procedures, protocols, and guidelines for response and care during a disaster/Bioterrorism event. These PCPs will provide guidelines to both EMS providers and trauma services as in the PCP for Burn Care. As information from the surveys becomes available, the Region will work with EMS and the Region 8 Hospital Bioterrorism Committee to develop this PCP. It is hoped that the same or similar PCPs can be developed for use across all regions to enhance care coordination across disciplines. The Regional Council will submit the new information to DOH for inclusion in the South Central Region's EMS & Trauma System Plan as it is developed.

2. Need Statement

There is a need to be able to better identify the current status of the region for all hazards preparedness and to carry out a plan to accomplish this within the biennium.

Communications

There is a need to improve the emergency communication systems within Public Health Region 8 and the South Central Region.

- There is a need for equipment such as radios, cell phones, satellite cell phones and communication towers that are needed to augment the current emergency communication system.
- There is a need for Emergency Medical Dispatch training including WMD awareness training. Emergency dispatch training is important so that consistent and accurate information such as location, type of call, and patient information can be given to the

responders. In addition, EMD trained dispatchers can provide pre-arrival instructions to the caller at the scene of an emergency event, that can save lives.

WMD awareness training

There is a need for standardized WMD training that is easily accessible to EMS providers and trauma service staff. DOH is in the process of developing and implementing this training.

WMD equipment

There is a need for WMD equipment for EMS providers. County Emergency Management Offices are in charge of obtaining and distributing EMS WMD equipment.

Mutual Aid

There is a need to clarify if the existing regional mutual aid agreements meet the needs for All Hazard Preparedness. The South Central Region All Hazards Committee is in the process of determining how best to meet the regional All Hazards mutual aid agreement needs. The Committee is utilizing the State Fire Mobilization model, with adjustment as needed.

WMD Drills

There is always a need for drills to determine the strengths and weaknesses of disaster/All Hazard planning. A regional functional drill is scheduled for early February 2005. Each county is holding tabletop exercises.

Interoperability

There is a need for established interoperability among agencies and across disciplines. The Regional Council has established an All Hazards Committee comprised of many of the agencies involved in disaster/All Hazards planning including EMS providers, county emergency managers, public health representatives, Amateur Radio Emergency Service, County EMS Directors, and hospital representatives.

Burn Care Capacity

There is a need to develop a plan for the care and transport of 50 severely burned adult and pediatric patients. There is a tremendous need for manpower and equipment to provide EMS care. DOH will be conducting a burn capacity survey for both EMS and trauma services in early 2005.

There is a need for a Regional Burn Care PCP. The region will utilize that information from the state burn care capacity survey to develop a burn care PCP, plan, protocols, and guidelines.

3. Goals

Goal 1: All hazards response planning that deploys EMS agencies to mass casualty events in Region 8 and the South Central Region.

Objective 1: Collaborate with EMS agencies, county EOCs and public health to provide guidelines for deployment of EMS agencies to mass casualty events throughout Region 8.

Strategy 1: Develop a Region 8 Mutual Aid agreement strategy by August 2005.

Strategy 2: Develop a Regional Patient Care Procedure for the triage and transport of 500 severely burned and injured adult and pediatric patients.

Cost

System Cost

The Federal Government and the State of Washington are investing hundreds of millions of dollars in equipment and training to better prepare the hospitals and EMS providers within the state, if an All Hazards event should occur.

The Regional Council does not have the technical nor financial resources to provide accurate and realistic costs of developing a comprehensive Bioterrorism plan for Region 8. The Regional Council is not capable of estimating the cost of EMS, hospital personnel and other professionals required to develop such a plan.

Regional Council Cost: The South Central Region receives \$45,000.00 per year to assist in developing and updating Region 8 Hospital Bioterrorism Plan and bring the EMS community into all hazards participation. These funds are expended toward a contract person shared with Public Health Region 8 to assist in providing the deliverables to DOH. This amount does not provide compensation for salary time that Regional Council Staff has devoted to Bioterrorism plan development.

Barriers:

The greatest barriers to Bioterrorism preparedness are all the unknowns of preparing for emergency trauma care for a huge number of patients with unknown injuries. Additionally, EMS agencies have not been actively involved in Bioterrorism planning.

B. Hospital Preparedness

1. System Status

Level of Collaboration across disciplines

The South Central Region works with Public Health Region 8 to bring together a wide array of participants for monthly Hospital Bioterrorism planning meetings. Participants include County EOCs, Amateur Radio Emergency Services, Tri City Laboratory, County Public Health agencies, trauma services, Yakama tribal representatives, LaClinica representatives, and infection control representatives from trauma services.

Regional Council's Role in Hospital planning

The South Central Region works with Public Health Region 8 in the development of a Hospital Bioterrorism Plan. The South Central Region has a DOH contract to assist Public Health Region 8. The Regional Council staff facilitates the monthly meetings, providing meeting minutes, email communications, and postal mailings as needed.

The Regional Council Administrator authored the first Public Health Region 8 Hospital Bioterrorism Plan. The Regional Council and Public Health share a contractor to do the update and revision of the Hospital Bioterrorism Plan

Status of the regional Bioterrorism Hospital Plan

Public Health Region 8 Hospital Bioterrorism Plan is being updated and revised and will be submitted to DOH. The Hospital Bioterrorism Committee continues to develop new portions of the plan as directed by DOH, such as Burn Care Capacity, Isolation and Quarantine and Negative Pressure Care.

WMD awareness training

Each trauma service is responsible for WMD training. DOH has supplied grants to reimburse for training. Trauma services are not responsible to report staff training to Public Health or the South Central Region. The Regional Council is not capable of providing accurate reliable information concerning hospital WMD training.

DOH has developed a web based WMD training at homelandtraining.org that is designed for both EMS and hospital personnel. Additional training such as Advanced Burn Life Support is planned for this site in the future.

WMD Hospital readiness equipment

The hospitals in Public Health Region 8 have completed two rounds of hospital equipment requests and one round of equipment purchase. Hospital equipment needs are reviewed, revised and prioritized before each purchase cycle. All Public Health Region 8 trauma services will receive Level C Biohazard Suits for staff and at least one portable Decontamination System by 2006. Many other identified needs such as security systems, equipment storage, portable respirators and others have been met. A complete list of equipment purchased and continuing equipment needs is available upon request from Public Health Region 8 or the South Central Region.

2. Need Statement:

Implementation of the plan

There is a need for all Public Health Region 8 hospitals to incorporate the Public Health Region 8 Hospital Bioterrorism Plan into their trauma service's internal disaster plans.

Awareness level training

There is a need for access to WMD training for trauma service personnel within Region 8.

Equipment

There is a need to improve the emergency communication systems within Public Health Region 8 and the South Central Region. Equipment such as radios, cell phones, satellite cell phones and communication towers are needed to augment the current emergency communication system.

There is a need for some area hospitals to increase hospital security for lockdown and control of access.

There is a need for additional negative pressure rooms in Public Health Region 8 hospitals.

Drills/exercises

There is always a need for drills to determine the strengths and weaknesses of disaster/All Hazard planning. County emergency management and hospitals also are required to test disaster and Bioterrorism plans on a regular basis.

Burn Care for 50 patients

There is a need to develop a plan to care for 50 burned and traumatized adult and pediatric patients. All of the Public Health Region 8 hospitals working together would not be able to adequately care for 50 burn patients.

There is a need for supplies and medications to stabilize 50 burned and traumatized patients.

There is a need to survey burn care capacity within Public Health Region 8.

3. Goals

Goal 1: Region 8 Hospital Bioterrorism Plan that provides care for mass casualty events in Region 8 and the South Central Region.

Objectives 1: Develop a plan that includes the roles of hospitals, local public health, and County Emergency Managers.

Strategy 1: Include in the plan general operational concepts, on-scene command, incident coordination and investigation, communications, incident command structure, and resource lists.

Strategy 2: *Implementation of the plan*- Public Health Region 8 has specifically designed its Hospital Bioterrorism Plan to meet JCHO hospital requirements for Bioterrorism planning and drills. A process and flow chart for accessing the National Stockpile push packets has been established.

Strategy 3: *Awareness level training* – Public Health Region 8 has facilitated the instillation of Telehealth Communication Systems in strategically located hospitals. Telehealth will help to make WMD training more accessible to hospital staff and to EMS providers near the hospitals. Training funds have also been made available to each hospital to assist staff in accessing WMD training.

Strategy 4: *Equipment* – such as security alarm systems, equipment and supply storage, portable respirators, portable negative pressure units, etc are being purchased and installed through the DOH equipment purchase process.

Strategy 5: *Drills/exercises*- Requirements have been met for drills and exercise with a table top drill in 2004 and a functional drill in 2005 with county EOCs, county public health agencies and hospitals participating.

Strategy 6: *Burn Care for 50 patients*- Assist DOH in collecting the Burn Care Capacity Survey and use the data to develop the Regional Patient Care Procedure for Burn Care.

Cost

System Cost

The Federal Government and the State of Washington are investing hundreds of millions of dollars into equipment and training to better prepare the hospitals and emergency providers within the state in case an All Hazards event should occur.

The Regional Council does not have the technical nor financial resources to provide accurate and realistic costs of developing a comprehensive Bioterrorism plan for Region 8. The Regional Council is not capable of estimating the cost of EMS, hospital personnel and other professional's time required to develop such a plan.

Regional Council Cost: The South Central Region receives \$45,000.00 per year to assist in developing and updating Region 8 Hospital Bioterrorism Plan and bring the EMS community into all hazards participation. These funds are expended toward a contract person shared with Public Health Region 8 to assist in providing the deliverables to DOH. This amount does not provide compensation for salary time that Regional Council Staff has devoted to Bioterrorism plan development.

Barriers

The greatest barriers to Bioterrorism preparedness are all the unknowns of preparing for emergency trauma care for a huge number of patients with unknown injuries. Participation in Region 8 Hospital Bioterrorism planning has been greatly enhanced with DOH contract funds provided to the hospitals.

Addendums

Addendum A - South Central Region Plan Goals

Authority

Goal 1: A functional and implemented EMS & Trauma Care System Plan within the South Central Region.

Goal 2: Estimated system costs.

Injury Prevention Goals

Goal 1: Death and injury are decreased in the top four categories of MVC, falls, poisoning, and drowning.

Goal 2: The use of child safety restraints throughout the region results in fewer MVC deaths and injury due to unrestrained children.

Goal 3: Increased helmet usage throughout the Region to decrease serious head injury.

Goal 4: Increased visibility of children/pedestrians during low light time by use of “Wildfeet” stickers.

Goal 5: Increase public awareness through activities and programs to prevent falls, especially in the elderly.

Goal 6: Increased public awareness activities to protect children from unintentional poisoning.

Goal 7: Increased public awareness of activities designed to reduce drowning deaths and near drowning injuries.

Goal 8: IPPE messages in other languages in addition to English are available in the Region.

Goal 9: Information about the new National Suicide Prevention Lifeline Number 1-800-273-TALK is available in the Region.

Prehospital

Goal 1: Enhanced day to day and disaster communication capabilities between emergency dispatch, EMS vehicles, hospitals, and between EMS agencies and other responding entities.

Goal 2: All emergency medical calls are handled by trained Emergency Medical Dispatchers who provided appropriate pre-arrival instructions from simple first aid to life saving instructions.

MPD

Goal 1: MPD awareness of Regional Council activities.

Trauma Verified EMS

Goal 1: Recruitment and retention of EMS providers.

Goal 2: Basic and State of the Art EMS equipment

Goal 3: SEI Instructors are available for County EMS training.

Goal 4: Updated training/education aids and equipment are available in the Region.

EMS

Goal 1: Trauma Verified EMS Services are available at the appropriate level in all areas of the Regional system.

PCPs

Goal 1: Patient Care Procedures and County Operating Procedures meet the needs for excellent patient care in the South Central Region.

Designated Trauma Services

Goal 1: Trauma Services are designated at the recommended number and levels in the South Central Region.

Information Management

Goal 1: Timely accurate and complete data collection and submission for use by regional CQI Committee.

Goal 2: Data is used by the Regional Council to access and analyze the Regional EMS & Trauma System needs.

CQI

Goal 1: Timely accurate and complete data collection and submission for use by the regional CQI Committee.

All Hazards**EMS**

Goal 1: All hazards response planning that deploys EMS agencies to mass casualty events in Region 8 and the South Central Region.

Hospitals

Goal 1: Region 8 Hospital Bioterrorism Plan that provides care for mass casualty events in Region 8 and the South Central Region.

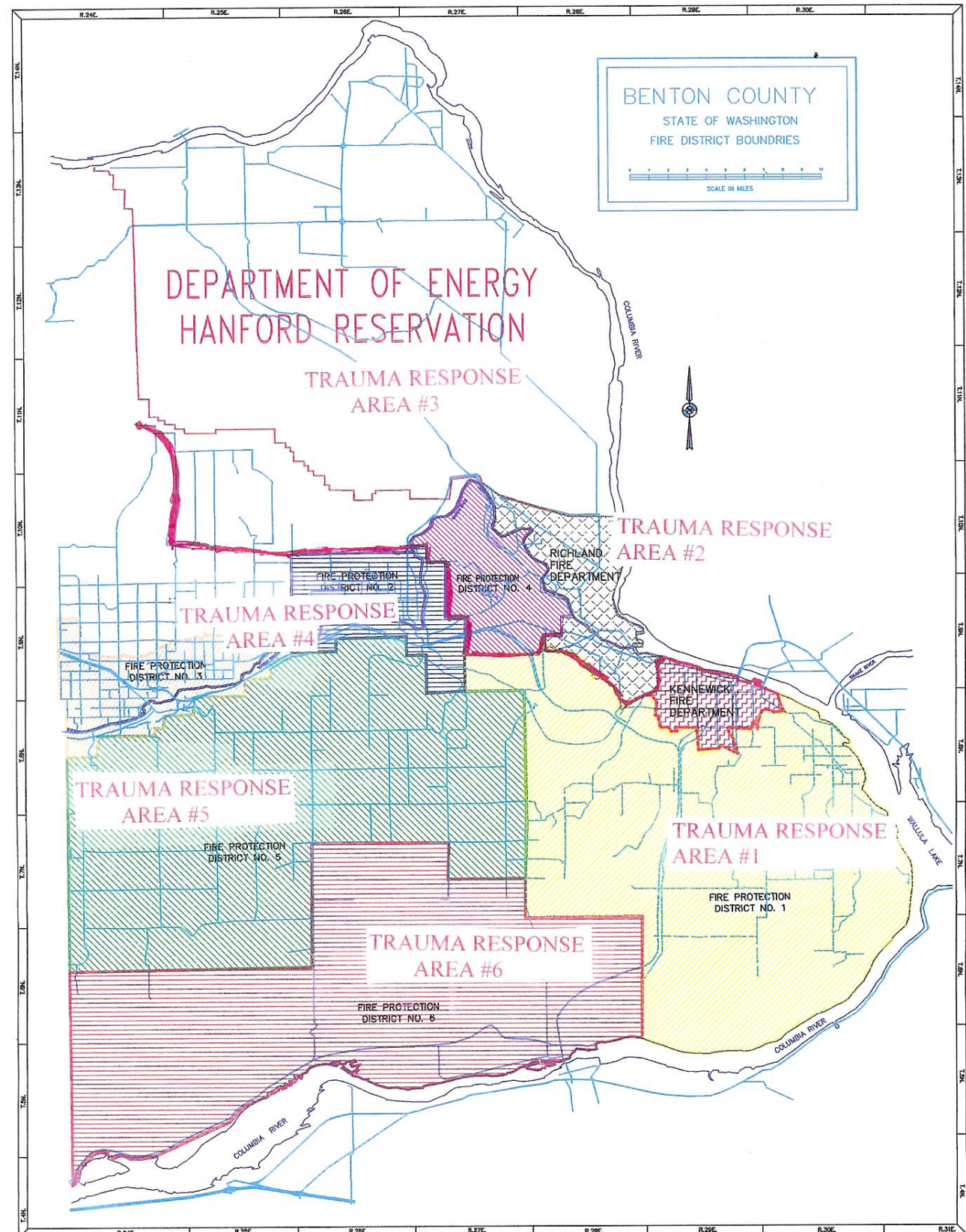
Addendum B – South Central Region EMS Training Equipment Needs

| EMS Training Equipment Needs 2004 | | | |
|-----------------------------------|------------------------|---|------------|
| Walla Walla Fire | 36M04 | 50 Backboards | \$5,000.00 |
| Walla Walla Fire | 36M04 | SimMan Disposable Supplies | \$1,800.00 |
| Fire District #8 | 36D08 | C Collar-Ambu "MiniAce" 6 | \$75.00 |
| Fire District #8 | 36D08 | BackBoard -"NAJO" Lite | \$99.00 |
| Fire District #8 | 36D08 | BackBoard-CombiCarrier" | \$450.00 |
| Fire District #8 | 36D08 | Splint-"Full Body vacuum mattress set | \$383.00 |
| Walla Walla FD#5 | 36D05 | Rescue Randy 105 lbs | \$642.00 |
| Walla Walla FD#5 | 36D05 | Defib/CPR Training Mannequin | \$1,100.00 |
| Walla Walla FD#5 | 36D05 | 3 Adult CPR Mannequins | \$483.00 |
| Walla Walla FD#5 | 36D05 | 3 Child CPR Mannequins | \$300.00 |
| Walla Walla FD#5 | 36D05 | 3 Baby CPR Mannequins | \$270.00 |
| Walla Walla Office of EMS | | CPR Mannequins-adult, child, baby | \$1,052.00 |
| Walla Walla Office of EMS | | First Responder/EMT Textbooks/student workbooks | \$1,000.00 |
| Walla Walla Office of EMS | | Laptop-projector | \$3,500.00 |
| WWFD # 4 | 36D04 | HT 750 Portable Radios 2 | \$1,500.00 |
| WWFD # 4 | 36D04 | Automatic External Defibrillator 1 | \$2,000.00 |
| WWFD # 4 | 36D04 | Glucometer 1 | \$150.00 |
| WWFD # 4 | 36D04 | Mosby's Paramedic Handbook 1 | \$100.00 |
| College Place Fire Department | 36M01 | 30 IV Maintenance set-ups | \$3,000.00 |
| College Place Fire Department | 36M01 | Glucometer Training Supplies/strips | \$150.00 |
| Franklin Co. FD #3 | 11D03 | InFocus Video Projector | \$2,350.00 |
| Benton Co. FD #4 | 03D04 | EMT Scenario Videos | \$2,500.00 |
| Prosser Ambulance | 03X01 | I.O. Trainer Kit Simulator | \$305.00 |
| Prosser Ambulance | 03X01 | Sternal I.O. FAST Simulator | \$300.00 |
| Prosser Ambulance | 03X01 | Mega Code Manikin | \$5,000.00 |
| Pasco Fire Department | 11M02 | Laptop-projector | \$2,000.00 |
| Pasco Fire Department | 11M02 | Power Point Projector | \$2,000.00 |
| Pasco Fire Department | 11M02 | CPR Mannequin | \$1,200.00 |
| Pasco Fire Department | 11M02 | Video Camera | \$1,000.00 |
| KC EMS Division | 19Z01 on behalf of: | 4 pack of Little Anne + airway | \$754.00 |
| KC FD #1 | 19D01 | 4 pack of Little Junior + airway | \$700.00 |

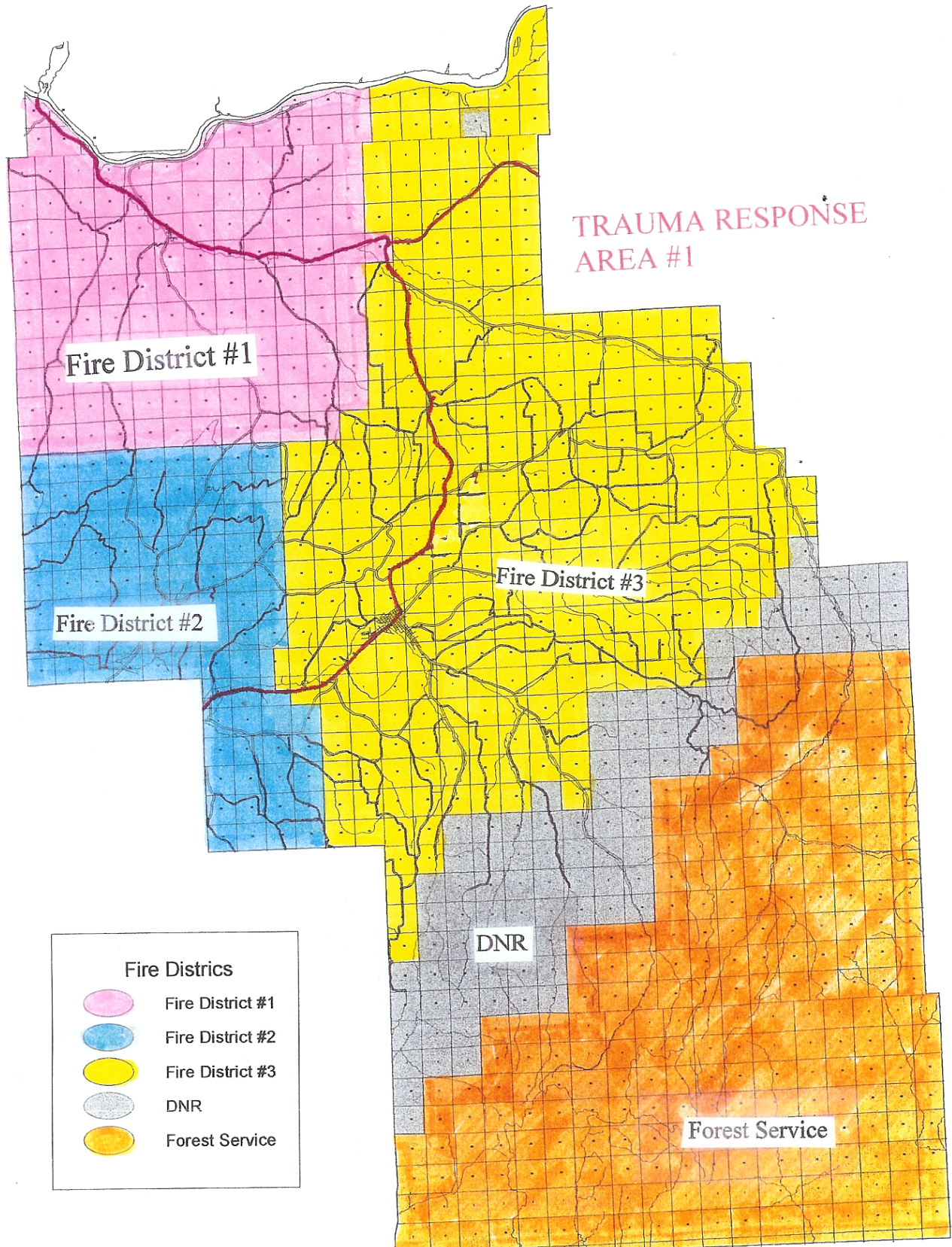
| EMS Training Equipment Needs 2004 | | | |
|--|-------|---|--------------------|
| KC FD #2 | 19D02 | 4 pack of Baby Anne + airway | \$370.00 |
| KC FD #3 | 19D03 | 2 O2 Regulators | \$240.00 |
| FC FD #4 | 19D04 | 1 Physio AED Lifepak 500 Trainer + Pads | \$500.00 |
| KC FD #7 | 19D07 | 5 Blood Pressure Cuffs | \$135.00 |
| KC FD #8 | 19D08 | 5 Stethoscopes | \$110.00 |
| Cle Elum FD | 19M01 | | |
| Roslyn FD | 19M04 | | |
| Kittitas FD | 19M05 | | |
| S, Cle Elum FD | 19M06 | | |
| KC Hosp. Dist #2 | 19X01 | Adult Airway Management Trainer Head | \$750.00 |
| Ellensburg FD | 19M02 | to be shared by the 2 ALS agencies | |
| Yakima County Dept. of EMS | 39Z01 | 4 Airway Larry Manikins w/Annie Bodies | \$3,959 |
| | | 2 year subscription to 24-7 EMS DVD Training Series | \$1,500 |
| | | Understanding Seizures & Epilepsy Video | \$30.00 |
| | | Bleeding & Shock Video | \$89.00 |
| | | Emergency in Stress Vol 1 Video | \$30.00 |
| | | EMS-Other Side of Fire Service Video | \$30.00 |
| | | Greater Philadelphia Wrecks and Pins, Vol 2 Video | \$26.00 |
| | | L.A. Rescue Video | \$30.00 |
| | | When Helping Hurts Sustaining Trauma Workers Video | \$105.00 |
| | | EMT-B 10 Tape Video Set | \$385.00 |
| | | Sick Not Sick Instructor's Toolkit | \$118.00 |
| TOTAL NEEDS/REQUESTS | | | \$49,570.00 |

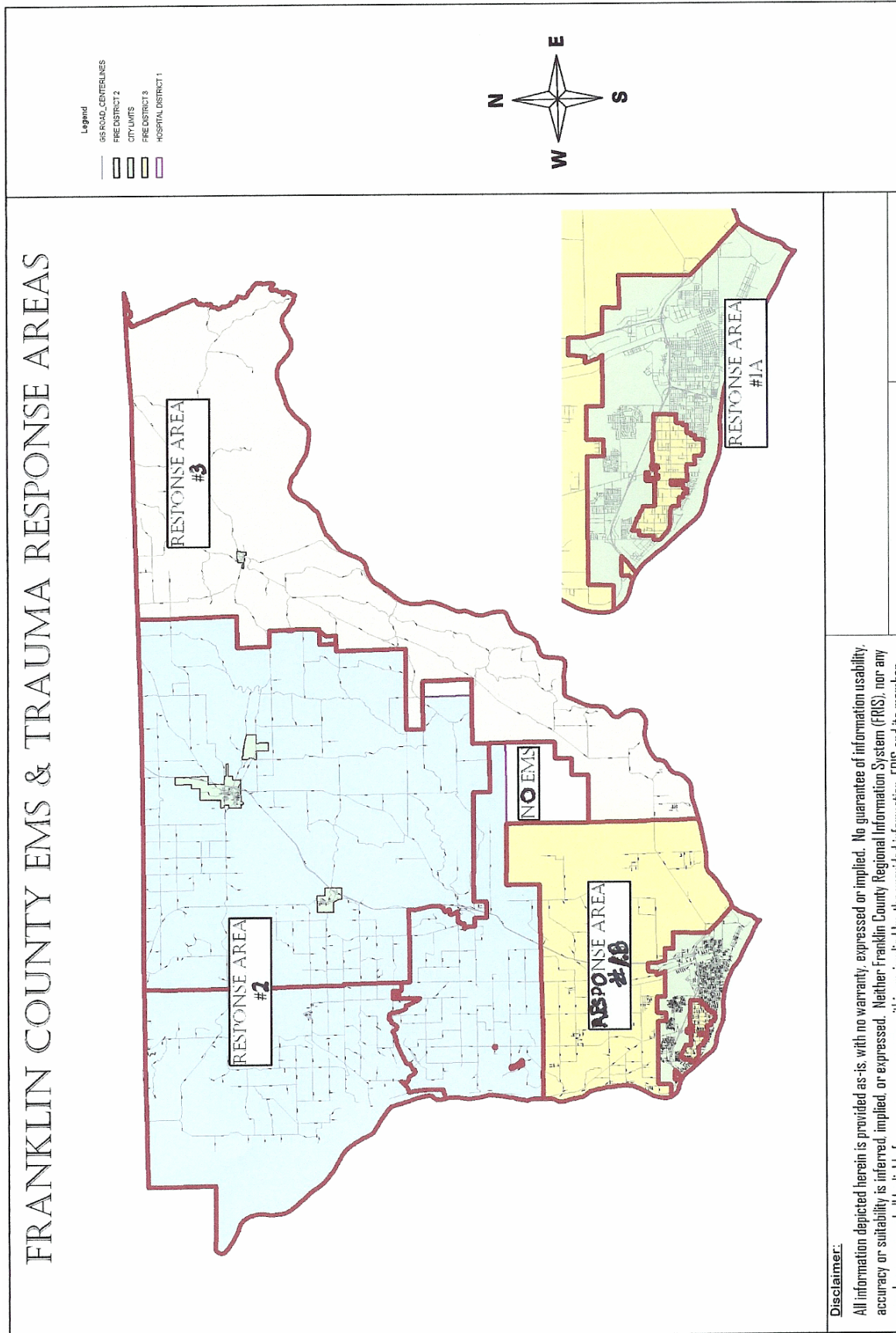
Addendum C - Trauma Area Maps

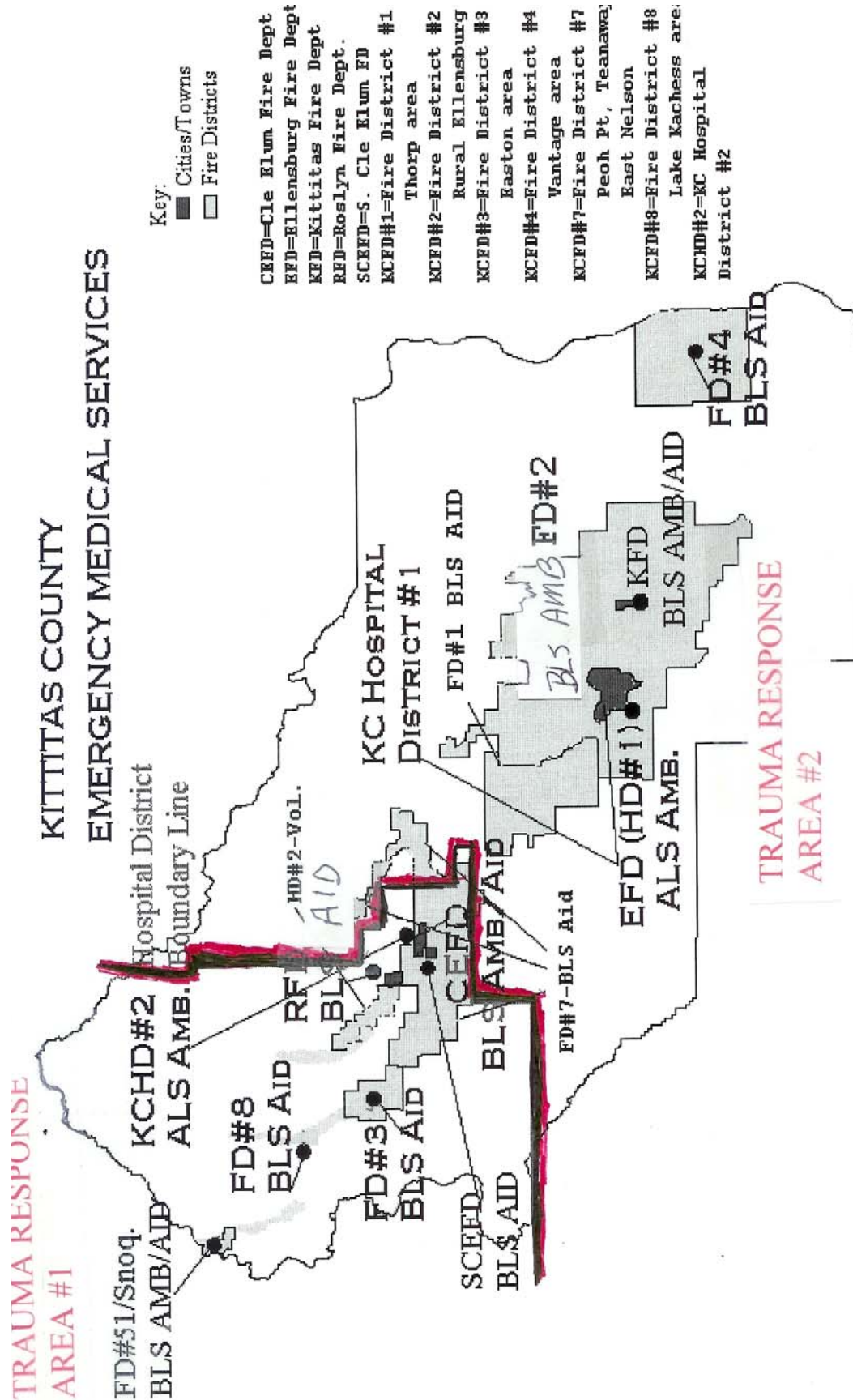
Benton County



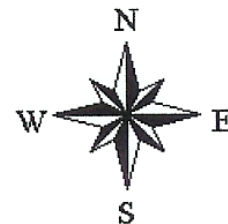
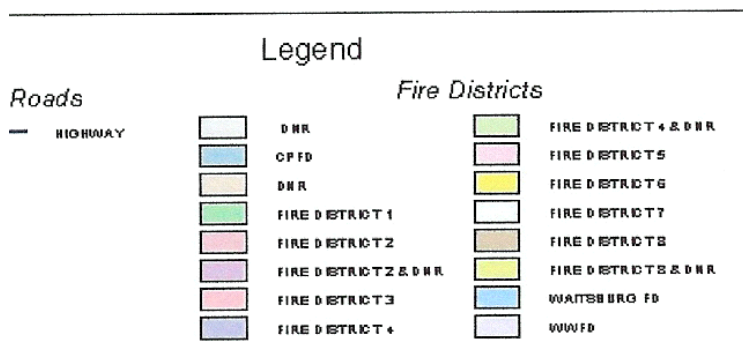
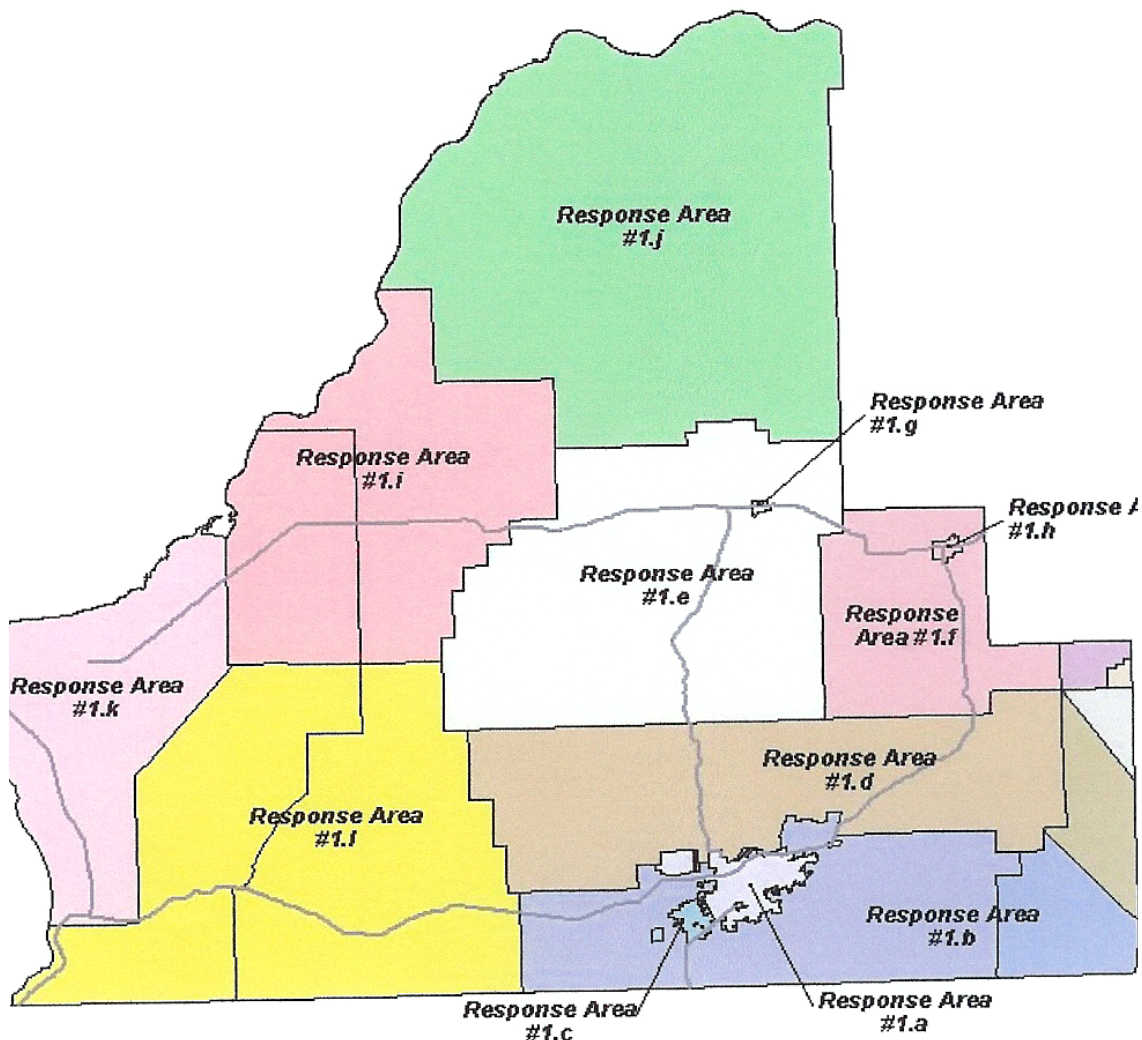
Columbia County Fire Districts



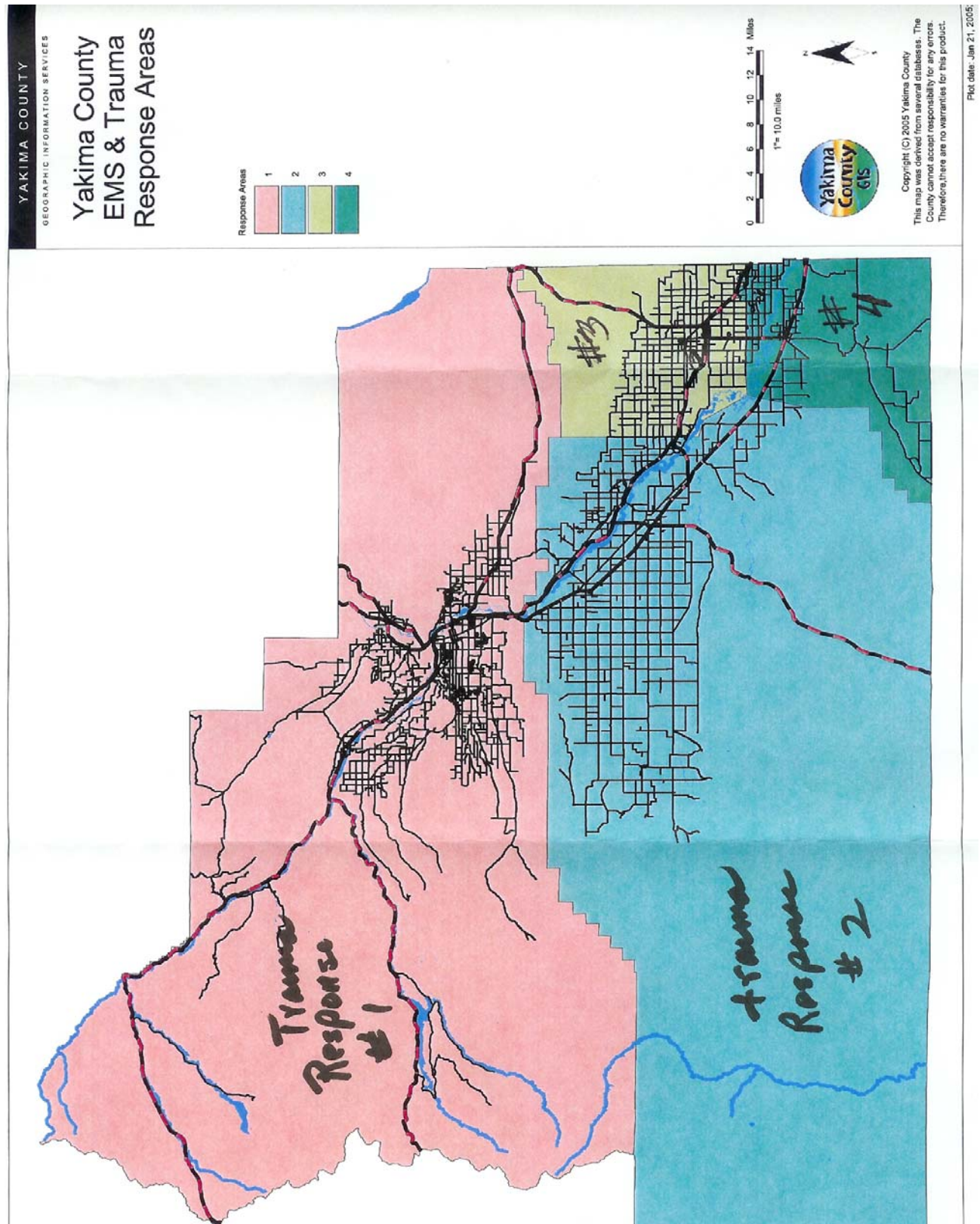




Walla Walla County EMS & Trauma Response Areas



Yakima County



Addendum D – South Central Region Patient Care Procedures

| South Central Region EMS & Trauma Care Council | | |
|--|------------------------------------|------------------------|
| | | |
| PATIENT CARE PROCEDURES #1 | Effective Date: 07/24/96 | Page: 1 of 2 |
| Subject: Dispatch | | |

I. STANDARD

1. Licensed aid and/or ambulance services shall be dispatched to all emergency medical incidents per the response maps developed by local EMS & Trauma Care Councils and the South Central Region.
2. Trauma verified aid and/or ambulance services shall be dispatched to all known injury incidents, as well as unknown injury incidents requiring an emergency response.

II. PURPOSE

To minimize “dispatch interval” and provide timely care by certified EMS personnel to all emergency medical and trauma patients.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. The nearest “appropriate” aid and/or ambulance service shall be dispatched per the above standards.
3. Trauma verified and licensed EMS services should proceed in an emergency response mode until they have been advised of non-emergent status.

IV. DEFINITION

1. **Appropriate** – Defined as the trauma verified or licensed EMS service that responds within an identified service area.
2. **Emergency Response** – Defined as a response using warning devices such as lights, sirens and use of Opticom devices where available.

| South Central Region EMS & Trauma Care Council | | |
|--|------------------------------------|------------------------|
| | | |
| PATIENT CARE PROCEDURE #1 | Effective Date: 07/24/96 | Page: 2 of 2 |
| Subject: Dispatch | | |

3. **Dispatch Interval** – Defined as the time the call is received by the dispatcher to the time the first unit is dispatched.

V. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #2 | Effective Date: | Page: |
| | 07/24/96 | 1 of 2 |
| Subject: Response Times | | |

I. STANDARD

All licensed and trauma verified aid and/or ambulance services shall respond to emergency medical and injury incidents in a timely manner in accordance with Washington Administrative Code (WAC).

II. PURPOSE

1. To provide “timely” emergency medical services to patients who have medical and/or injury incidents requiring emergency care response.
2. To collect data required by the state Trauma Registry and by the regional Continuous Quality Improvement (CQI) Plan.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. Detailed maps of service areas are available through the South Central Regional office.
3. Trauma verified aid and/or ambulance services shall collect documentation for the Washington State Trauma Registry (WAC).
4. Included in the Trauma Registry information will be unit response time. Verified aid and/or ambulance services shall meet the minimum agency responses to response area as defined in WAC.

Trauma Verified AID Service

| | |
|------------|----------------------------|
| Urban | 8 Minutes-80% of the time |
| Suburban | 15 Minutes-80% of the time |
| Rural | 45 Minutes-80% of the time |
| Wilderness | as soon as possible |

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #2 | Effective Date: | Page: |
| | 07/24/96 | 2 of 2 |
| Subject: Response Times | | |

Trauma Verified AMBULANCE Service

| | |
|------------|----------------------------|
| Urban | 8 Minutes-80% of the time |
| Suburban | 20 Minutes-80% of the time |
| Rural | 45 Minutes-80% of the time |
| Wilderness | as soon as possible |

IV. DEFINITIONS

1. **Urban** – Incorporated area over thirty thousand; or an incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square miles (WAC).
2. **Suburban** – Incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of less than 1,000 to 2,000 people per square mile (WAC).
3. **Rural** – Incorporated or unincorporated areas with total population less than 10,000 or with a population density of less than 1,000 per square mile (WAC).
4. **Wilderness** – Any rural area that is not accessible by public or private maintained roadways (WAC).
5. **Response Time** – Interval of time from agency notification to arrival on the scene. It is the combination of activation and in route times defined under response times (WAC).
6. **EMS Personnel** – First Responder skill level or higher

V. QUALITY ASSURANCE

The South Central Region CQI Committee, consisting of at least one member of the designated facilities medical staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional Standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #3 | Effective Date: | Page: |
| | 07/24/96 | 1 of 4 |
| Subject: Triage And Transport | | |

I. STANDARD

All licensed and trauma verified aid and/or ambulance services shall comply with the State of Washington Prehospital Trauma Triage Destination Tool as defined in Washington Administrative Code (WAC). Medical and injured patients who do not meet prehospital triage criteria will be transported to local facilities according to Regional Patient Care Procedures (PCPs), MPD protocols and County Operating Procedures (COPs).

II. PURPOSE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. To ensure that all trauma patients are transported to the most appropriate trauma designated facility in accordance with WAC.
3. To ensure that all patients that do not meet Trauma Triage Tool Criteria are transported according to COPs.
4. To allow the receiving facility or trauma designated service adequate time to activate their emergency medical and/or trauma response team.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may recommend local COPs that meet or exceed the STANDARD and PURPOSE described above, and provide a copy to the Regional Council for adoption.
2. Trauma Triage
 - a. The first certified EMS provider to determine that a patient meets the trauma triage criteria, shall contact their base station, medical control, or the receiving trauma service via their local communication system, as soon as possible.

| South Central Region EMS & Trauma Care Council | | |
|---|------------------------|---------------|
| PATIENT CARE PROCEDURE #3 | Effective Date: | Page: |
| | 07/24/96 | 2 of 4 |
| Subject: Triage And Transport | | |

- b. EMS Providers and their organizations shall transport patients in accordance with the Washington State Trauma Triage Destination Procedure, Regional Patient Care Procedures (PCPs), and COPs.
- c. The Medical Control and/or receiving facility should be provided with the following information, as outlined in the Prehospital Trauma Triage Destination Procedure:
 - i. Vital signs
 - ii. Level of Consciousness
 - iii. Anatomy of Injury
 - iv. Biomechanics of Injury
 - v. Co-morbid Factors
- d. Major trauma patient will be identified as the following:
 - i. Patients meeting the first two steps of the current State of Washington Prehospital Trauma Triage Procedures published by DOH-EMS or any other DOH approved triage tool.
 - ii. Patients activating the Region's Trauma Services and hospitals in-house and full trauma team activation.
 - iii. Patients included by the Region's Prehospital services, designated trauma services, and hospitals in the State Trauma Registry using the Trauma Registry inclusion criteria as outlined in WAC.
- e. If a patient meets the trauma triage criteria, a Washington State Trauma Registry Band should be attached to the patient's wrist/ankle.
- f. Patients meeting trauma triage criteria are major trauma patients who may or may not have the ability to make an informed decision. They shall be transported to a designated trauma service in accordance with the State of Washington Prehospital Trauma Triage Destination Procedure or other DOH approved trauma triage destination procedure.
- g. If prehospital personnel are unable to effectively manage a trauma patient's airway, an Advanced Life Support (ALS) rendezvous or an immediate stop at the nearest facility capable of immediate definitive airway management should be considered.

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #3 | Effective Date: | Page: |
| | 07/24/96 | 3 of 4 |
| Subject: Triage And Transport | | |

- h. South Central Region Designated Trauma services and maps of their locations are available from the Regional Council Office.
- i. Designated trauma services shall have written procedure and protocol for diversion of trauma patients when the facility is temporarily unable to care for trauma patients. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the decision to divert when stabilization in the closest emergency department might be life saving.

Note: Exceptions to diversion:

Airway compromise
Traumatic arrest
Active seizing
Persistent shock
Uncontrolled hemorrhage
Urgent need for IV access, chest tube, etc
Disaster

3. Non-Trauma/Medical

- a. Prehospital personnel may request response or rendezvous with ALS/ILS providers and all EMS providers may request emergency aero-medical evacuation if they are unable to effectively manage a patient.
 - b. Medical and injured patients who do not meet prehospital triage criteria for trauma system activation will be transported to local facilities according to local MPD protocols and COPs.
 - c. While in route and prior to arrival at the receiving facility, the transporting agency should provide a complete report to the receiving hospital regarding the patient's status via radio or other approved communication system according to local MPD protocols and COPs.
4. Before leaving the receiving facility, the transporting agency will leave a completed MPD approved medical incident report (MIR) form or provide the information that entered the patient into the trauma system in the "receiving facility" approved method. The additional information from the MIR shall be made available to the receiving facility as soon as possible in accordance with WAC.

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #3 | Effective Date: | Page: |
| | 07/24/96 | 4 of 4 |
| Subject: Triage And Transport | | |

IV. DEFINITION

Designated Trauma Service – A health care facility or facilities in a joint venture, whom have been formally determined capable of delivering a specific level of trauma care by the DOH.

V. QUALITY ASSURANCE

The South Central Region CQI Committee, consisting of at least one member of each designated facilities medical staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #4 | Effective Date: | Page: |
| | 07/24/96 | 1 of 2 |
| Subject: Interfacility Transfer | | |

I. STANDARD

1. All interfacility trauma patient transfers via ground or air shall be provided by a trauma verified service with personnel and equipment to meet trauma patient needs.
2. Immediately upon determination that a patient needs exceed the scope of practice and/or protocols, EMS personnel shall advise the facility that they do not have the resources to do the transfer (WAC).

II. PURPOSE

Provide a procedure that will achieve the goal of transferring high-risk trauma and medical patients without adverse impact to clinical outcomes.

III. PROCEDURES

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. Medical responsibility during transport should be arranged at the time of the initial contact between receiving and referring physicians, and transfer orders should be written after consultation between them.
3. Prehospital protocols shall be followed during an EMS transport in the event that an emergency situation occurs while in route that is not anticipated prior to transport.
4. While in route, the transporting agency should communicate patient status and estimated time of arrival (ETA) to the receiving facility per local protocols and COPs.

IV. DEFINITION

Authorized Care – Patient care within the scope of approved level of EMS certification and /or specialized training as described in WAC.

| South Central Region EMS & Trauma Care Council | | |
|---|------------------------|---------------|
| PATIENT CARE PROCEDURE #4 | Effective Date: | Page: |
| | 07/24/96 | 2 of 2 |
| Subject: Interfacility Transfer | | |

V. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|---|-----------------|---------------|
| PATIENT CARE PROCEDURE #5 | Effective Date: | Page: |
| | 07/24/96 | 1 of 1 |
| Subject: Medical Command At Scene | | |

I. STANDARD

The Incident Command System (ICS) shall be used.

II. PURPOSE

To define who is in medical command at the EMS scene and to define the line of command when multiple EMS agencies respond.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. Medical Command will be assigned by the Incident Commander.
3. Whenever possible, the Medical Commander/Medical Group Supervisor will be an individual trained in the ICS, familiar with both the local EMS resources and the county Mass Casualty Incident and Disaster Plan, and capable of coordinating the medical component of a multiple patient incident.

IV. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS and Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Regional CQI Committee will analyze data for patterns and trends and for compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|---|-----------------|---------------|
| PATIENT CARE PROCEDURE #6 | Effective Date: | Page: |
| | 07/24/96 | 1 of 2 |
| Subject: EMS/Medical Control Communications | | |

I. STANDARD

Communications between Prehospital personnel, trauma services, and health care facilities will utilize the most effective communication means to expedite patient information exchange.

II. PURPOSE

To define methods of expedient communications between prehospital personnel and trauma services, other health care facilities, and medical control.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. The State of Washington (Office of EMS & Trauma) and the South Central Region EMS & Trauma Care Council will coordinate with the prehospital providers and trauma services, and other health care facilities, to develop the most effective communication system based on the EMS provider's geographic and resource capabilities.
3. Communication between EMS providers, trauma services, and health care facilities can be "direct" to trauma services or health care facilities or communications can be "indirect" from dispatching agency to trauma services or health care facilities.
4. County EMS/trauma councils will be responsible for establishing communication procedures between the EMS provider(s) and the trauma service(s) or health care facilities with input from the County Medical Program Director (MPD).
5. EMS agencies will maintain communication equipment and training needed to communicate in accordance with WAC.
 - a. Ground ambulance and aid services shall provide each licensed vehicle with communication equipment which:
 - 1) Is in good working order.
 - 2) Allows direct two-way communication between the vehicle and its system control point.
 - 3) If cellular phones are used, there must also be a method for radio contact with dispatch and medical control.

| South Central Region EMS & Trauma Care Council | | |
|--|------------------------|---------------|
| PATIENT CARE PROCEDURE #6 | Effective Date: | Page: |
| | 07/24/96 | 2 of 2 |
| Subject: EMS/Medical Control Communications | | |

- b. In addition, prehospital services shall provide each licensed ambulance with communication equipment which:
- 1) Allows direct two-way communication, from both the driver's and patient's compartments, with all hospitals in the service area of the vehicle.
 - 2) Incorporates appropriate encoding and selective signaling devices if appropriate.
 - 3) When transporting patients out of normal service area, allows for communications with receiving facilities.

IV. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|---|------------------------|---------------|
| PATIENT CARE PROCEDURE #7 | Effective Date: | Page: |
| | 07/24/96 | 1 of 2 |
| Subject: Helicopter Alert And Response | | |

I. STANDARD

Request emergency medical helicopter to the scene of a critical trauma patient as soon as possible.

II. PURPOSE

To define the criteria for request of on-scene emergency medical helicopter and who may initiate the request.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. On-scene emergency medical helicopter may be requested for patients in areas greater than 30 minutes ground ambulance transport time from a hospital who meet the first two steps of the Washington State Trauma Triage Tool or as directed by medical control.
3. The highest level EMS certified person on-scene should determine the need for on-scene emergency medical helicopter response, however on-scene law enforcement personnel may request emergency medical helicopter response when EMS personnel are not readily available.
4. Request for on-scene emergency medical helicopter should be initiated through the appropriate emergency dispatch agency. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units.
5. The emergency medical helicopter will transport the trauma patient to the highest designated level trauma service within 30 minutes air transport time from the scene.
6. The helicopter will make radio contact with the receiving trauma service as soon as possible.

| South Central Region EMS & Trauma Care Council | | |
|---|------------------------|---------------|
| PATIENT CARE PROCEDURE #7 | Effective Date: | Page: |
| | 07/24/96 | 2 of 2 |
| Subject: Helicopter Alert And Response | | |

IV. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional Standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #8 | Effective Date: | Page: |
| | 07/24/96 | 1 of 2 |
| Subject: Diversion | | |

I. STANDARD

All designated trauma services within the Region will have hospital approved policies to divert trauma patients to other designated trauma facilities.

II. PURPOSE

1. To divert trauma patients to other designated trauma facilities based on the facilities inability to provide initial resuscitation, diagnostic procedures, and operative intervention (WAC).
2. To identify communication procedures for diversion of trauma patients to another accepting facility.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. Each trauma service will have written policies and procedures that outline reasons to divert trauma from their service (WAC).
3. Trauma Services must consider diversion when essential services including but not limited to the following are not available:
 - a. Surgeon
 - b. OR
 - c. For a Level II - CT
 - d. For a Level II – Neuro Surgeon
 - e. ER is unable to manage additional patients

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #8 | Effective Date: | Page: |
| | 07/24/96 | 2 of 2 |
| Subject: Diversion | | |

4. When the trauma service is unable to manage major trauma, they will have an established procedure to notify the EMS transport agencies and other trauma services in their area that they are on trauma divert. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the decision to divert when stabilization in the closest emergency department might be life saving.

Note: Exceptions to diversion:

- a. Airway compromise
 - b. Traumatic arrest
 - c. Active seizing
 - d. Persistent shock
 - e. Uncontrolled hemorrhage
 - f. Urgent need for IV access, chest tube, etc
 - g. Disaster
5. Each designated trauma service will maintain a diversion log providing time, date and reason for diversion. This log will be made available to the regional CQI Committee for review if required.

IV. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|---|------------------------|---------------|
| PATIENT CARE PROCEDURE #9 | Effective Date: | Page: |
| | 05/22/97 | 1 of 2 |
| Subject: BLS/ILS Ambulance Rendezvous With ALS Ambulance | | |

I. STANDARD

In service areas with only BLS/ILS ambulances, a “rendezvous” with an ALS response will be “attempted” for all patients who may benefit from ALS intervention.

II. PURPOSE

To provide ALS intervention based on patient illness and or injury, and the proximity of the receiving facility in areas serviced by only BLS/ILS ambulances.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. Local EMS & Trauma Care Councils and MPDs that choose not to adopt their own protocol or policy shall adhere to the following procedures:
 - a. Emergency Medical Dispatch Guidelines will be used to identify critically ill or injured patients.
 - b. When an ALS response is deemed necessary or requested, the ALS service shall be dispatched with the BLS/ILS ambulance or as soon as possible.
3. The BLS/ILS ambulance may request ALS ambulance rendezvous at anytime.
4. Based on updated information, BLS/ILS personnel either while in route or on scene may determine that ALS intervention is not needed. The responding ALS ambulance may be notified and given the option to cancel.
5. Upon rendezvous, the method of transport, i.e., BLS vehicle or ALS vehicle, shall be in the best interest of the patient’s care in accordance with RCW 18.71.210.

| South Central Region EMS & Trauma Care Council | | |
|---|-----------------|---------------|
| PATIENT CARE PROCEDURE #9 | Effective Date: | Page: |
| | 05/22/97 | 2 of 2 |
| Subject: BLS/ILS Ambulance Rendezvous With ALS Ambulance | | |

IV. DEFINITION

1. **ALS** – Advanced Life Support as defined in WAC 246-976.010.
2. **Attempted** – After identification of the need for ALS intervention, every effort will be made to arrange a BLS/ILS ambulance with ALS ambulance rendezvous.
3. **BLS** – Basic Life Support as defined in WAC 246-976-010.
4. **Emergency Medical Dispatch Guidelines** – Established and accepted emergency medical dispatching guidelines that utilize specific questions and responses to determine EMS levels to be dispatched.
5. **ILS** – Intermediate Life Support as defined in WAC 246-976-010.
6. **Rendezvous** – A pre-arranged agreed upon meeting either on scene, in route from or another specified location.

V. QUALITY IMPROVEMENT

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|---|------------------------|---------------|
| PATIENT CARE PROCEDURE #10 | Effective Date: | Page: |
| | 05/22/97 | 1 of 1 |
| Subject: Trauma System Data Collection | | |

I. STANDARD

Trauma verified EMS agencies and designated trauma services shall collect the required Trauma Registry data. Trauma Services will submit Trauma Registry Data to the Department of Health per WAC.

II. PURPOSE

1. To have a means to monitor and evaluate patient care and outcomes and the effectiveness of the EMS and Trauma Care delivery system.
2. EMS agencies will identify trauma patients using the parameters set by the Washington State Trauma Triage Tool or other DOH approved triage tool.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. EMS agencies will identify trauma patients using the parameters set by the Washington State Trauma Triage Tool or other DOH approved triage tool.
3. Designated trauma services will identify trauma patients using the Trauma Registry inclusion criteria.

IV. QUALITY IMPROVEMENT

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #11 | Effective Date: | Page: |
| | 09/15/99 | 1 of 2 |
| Subject: Routine EMS Response Outside Recognized Service Coverage Zone | | |

I. STANDARD

Establish a continuum of patient care per the South Central Region EMS & Trauma Care Council's Trauma Plan.

II. PURPOSE

1. Provide an avenue for reliable EMS agency relationships and coordination of optimal trauma/medical patient care as described in the Regional Trauma Plan.
2. Provide for the safety of crews, patients, the public and other emergency responders.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. Local EMS & Trauma Care Councils will identify EMS agencies within the South Central Region and from other regions who routinely respond into areas beyond their recognized service coverage zone to provide ambulance service.
3. Local EMS & Trauma Care Councils will identify and encourage specific EMS Mutual Aid Agreements among EMS agencies that routinely respond into other service coverage zones that address the following:
 - a. Dispatch Criteria
 - b. Highest level of appropriate trauma verified EMS care utilized
 - c. Transport to the appropriate designated trauma service or medical facility

| South Central Region EMS & Trauma Care Council | | |
|--|-----------------|---------------|
| PATIENT CARE PROCEDURE #11 | Effective Date: | Page: |
| | 09/15/99 | 2 of 2 |
| Subject: Routine EMS Response Outside Of Recognized Service Coverage Zone | | |

4. Establish emergency response routes and notification standards.
 - a. When in route to a facility outside routine response area for the purpose of patient transfer, and when the response requires emergency response that crosses jurisdictional boundaries of counties, the base dispatch center may contact dispatch centers in those jurisdictions giving the route of travel, time of estimated arrival and destination.
 - b. If transporting agency will be leaving the area in an emergency response mode, the procedure above may be followed.

IV. DEFINITION

1. **Routine** – Usual or established “response zone”.
2. **Response Area** – A service coverage zone identified in an approved regional trauma plan.
3. **Emergency Response** – Defined as a response using warning devices such as lights and sirens and use of Opticom devices where available.

V. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|---|-----------------|---------------|
| PATIENT CARE PROCEDURE #12 | Effective Date: | Page: |
| | 09/15/99 | 1 of 2 |
| Subject: Emergency Preparedness/Special Responders | | |

I. STANDARD

Each county Emergency Management Administration within the South Central Region shall have a written Emergency Preparedness plan that includes EMS and health care facilities per RCW and WAC.

II. PURPOSE

To assure that the county Emergency Preparedness written plan addresses EMS and designated trauma services roles and responsibilities in multi-casualty and disaster incidents.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. Local EMS & Trauma Care Councils will verify that EMS agencies and designated trauma services roles and responsibilities in county emergency preparedness plans are included and accurate.
3. Local EMS & Trauma Care Councils will verify and submit as an addendum a list of special responders from each county's emergency preparedness plans.

IV. DEFINITION

1. Special Responders – Organizations or individuals who provide and contribute emergency response and skills outside the usual and customary EMS response.

| South Central Region EMS & Trauma Care Council | | |
|---|---|-------------------------------|
| PATIENT CARE PROCEDURE #12 | Effective Date: 09/15/99 | Page: 2 of 2 |
| Subject: Emergency Preparedness/Special Responders | | |

V. QUALITY ASSURANCE

The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

| South Central Region EMS & Trauma Care Council | | |
|--|----------------------------------|------------------------|
| | | |
| PATIENT CARE PROCEDURES # 13 | Effective Date: 2/2006 | Page: 1 of 2 |
| Subject: All Hazards-MCI-Severe Burns (Washington State DOH Approved Plan Modifications - 1/18/2006) | | |

I. STANDARD: During an all hazards mass casualty incident (MCI) that can include severely burned adult and pediatric patients;

1. All verified ambulance and verified aid services shall respond as requested to an MCI per local MCI plans, County Operating Procedures and Regional Patient Care Procedures.
2. When activated by dispatch in support of the local MCI Plan and/or in support of verified EMS services, all licensed ambulance and licensed aid services may respond to assist during an MCI.
3. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
4. All EMS agencies working during an MCI event shall operate within the National Incident Management System (NIMS).

II. PURPOSE

1. To develop and communicate the information of the South Central Region EMS & Trauma System Plan, Section VII prior to an MCI.
2. To implement local MCI plans during an MCI.
3. To provide trauma care including burn for at least 50 severely injured adult and pediatric patients within the South Central Region.
4. To provide safe mass transportation with pre-identified personnel, equipment and supplies per the approved local MCI plan.

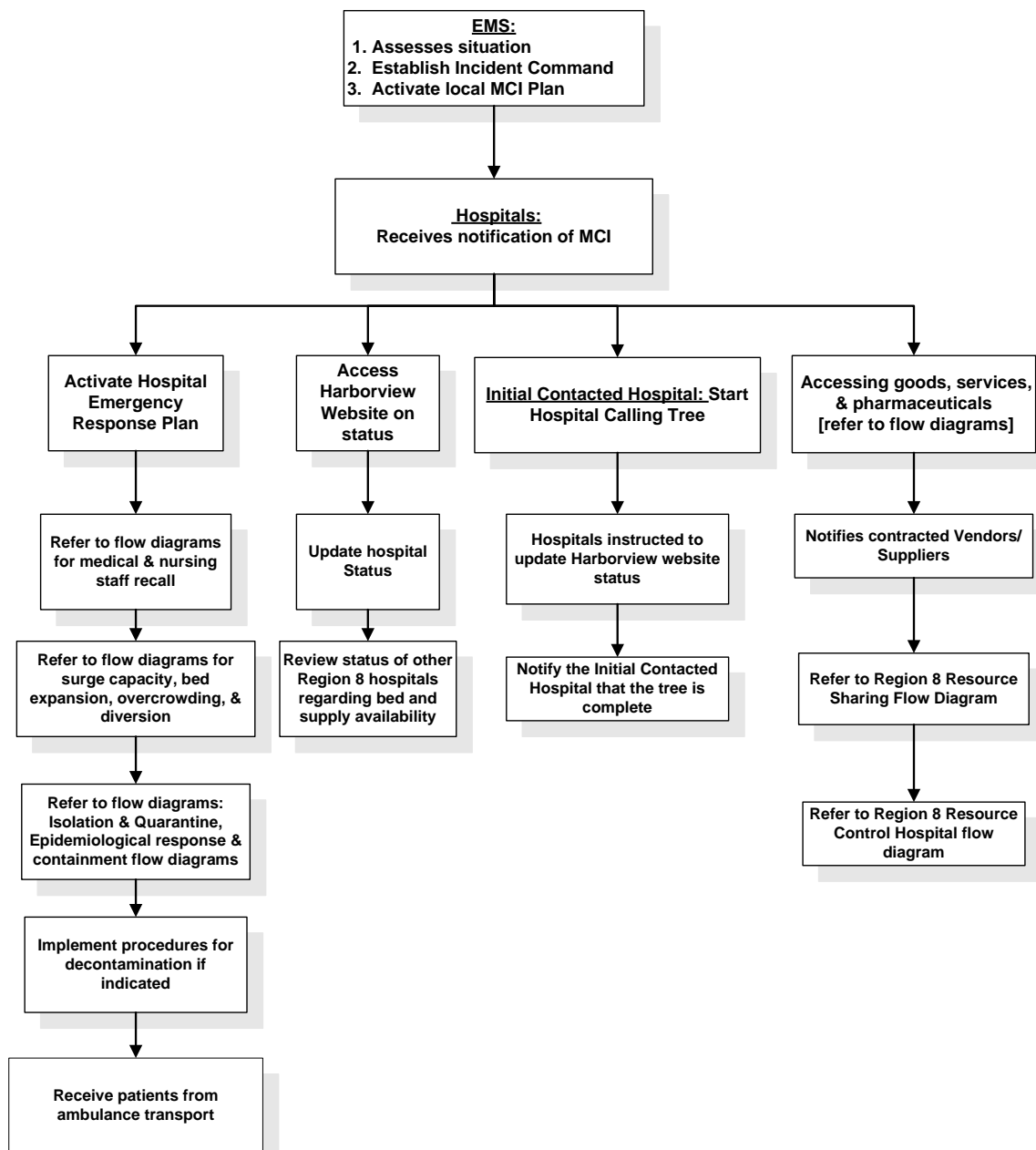
III. PROCEDURE

1. Incident Commanders shall follow the local MCI Plan to inform medical control when an MCI condition either CBRNE or NON-CBRNE exists.
2. Medical Program Directors have agreed that local protocols will be used by the responding agencies throughout the transport of patients, whether it be in another county, region or state. This will ensure consistent patient care in the field by personnel trained to use specific medications, equipment, procedures, and/or protocols until the patient is delivered to a receiving facility.
3. EMS personnel may use the "Region 8 Hospital Multi Casualty Incident (MCI) Response Algorithm during the MCI incident.

IV. DEFINITION

CBRNE – Chemical, Biological, Radiological, Nuclear, Explosive

REGION 8 HOSPITAL MULTI-CASUALTY INCIDENT [MCI] RESPONSE



Addendum E - South Central Region County Operating Procedures (COPS)

Benton/Franklin (Mid Columbia) County Operating Procedures

| | | |
|---|---------------------------|-----------------|
| Benton/Franklin Counties POLICY #1 | Effective Date: 9/3/96 | Page: 1 of 1 |
| SUBJECT: HELICOPTER ALERT & RESPONSE | | |

I. STANDARD:

Initiate a helicopter with ALS EMS personnel to the scene of a traumatic incident as soon as deemed necessary

II. PURPOSE:

To define the criteria for request of on-scene ALS helicopter and who may initiate the request.

III. PROCEDURE:

1. The highest level EMS certified person on-scene should determine the need for on-scene helicopter response, however on-scene law enforcement personnel with appropriate training may request helicopter response when EMS personnel are not readily available.
2. Request on-scene ALS helicopter should be initiated through the appropriate emergency dispatching agency with input from and assistance of medical control. The dispatching agency will provide the helicopter with the correct radio frequency to use to contact the ground unit.
3. The ALS helicopter will transport the trauma patient to the highest level designated trauma service within 30 minutes air transport time.
4. The helicopter will make radio contact with the receiving trauma service en route to and shortly after lift off from the scene.

IV. QUALITY ASSURANCE:

1. Reports of helicopter launches including cancels and transports with destinations will be submitted to the regional CQI committee. These will be reviewed, with local input, to develop a definition of the most appropriate circumstances for helicopter request.

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|---|-----------------------------|-----------------|
| BENTON/FRANKLIN COUNTIES POLICY # 2 | Effective Date: 10/18/97 | Page: 1 of 1 |
| SUBJECT: EMS/MEDICAL CONTROL COMMUNICATION | | |

I. STANDARD:

Communications between Prehospital personnel and Medical Control will be standardized for all complicated medical and trauma patients.

II. PURPOSE:

To define methods of expedient communications between Prehospital personnel and Medical Control.

III. PROCEDURE:

1. Contact Medical Control a minimum of three times for all complicated medical and trauma patients.
 - a. En Route
 - b. At the scene, with quick scene size-up
 - c. Report with pertinent patient information
2. Respond and transport Code 3 to all cases where TPA may be indicated i.e. CVA and MI.

IV. QUALITY ASSURANCE

1. Communication problems will be reviewed through local measures and reported to the Regional CQI committee for review if necessary.
2. Communication problems effecting patient care will be reviewed locally and reported to the Regional CQI committee for review.

| | | |
|--|--|-----------------|
| BENTON/FRANKLIN COUNTIES POLICY # 3 | Effective Date: 9/1/91 Updated: 8/1/96 | Page: 1 of 1 |
| SUBJECT: USE OF AV PRESENTATION FOR CME | | |

I. STANDARD:

All EMS providers are required to have continuing medical education to maintain their certification.

II. PURPOSE:

To provide a policy in which the Medical Program Director (MPD) or designee may pre-approve audiovisual presentations as accredited continuing medical education (CME) for prehospital personnel.

III. PROCEDURE:

1. First Responder, EMTs and Paramedics may utilize audiovisual presentations, such as videotapes or slide/tape presentations, as approved CME
2. Audiovisual presentation used shall be pre-approved
3. A maximum of 25% of the EMS providers CME requirements may be in the form of an audiovisual presentation.

IV. QUALITY ASSURANCE:

1. The MPD, or designee, may utilize written exams or other methods as necessary, in order to verify viewing of the presentation by an individual

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| BENTON/FRANKLIN COUNTIES POLICY # 4 | Effective Date: 4/1/91 | Page: 1 of 1 |
| SUBJECT: ACLS REQUIREMENT | | |

I. STANDARD:

To retain Protocol Privilege within Benton-Franklin Counties all prehospital ALS personnel shall maintain a current ACLS certification.

II. PURPOSE:

To assure that the ACLS care giver has the most current information provided by the American Heart Association for the treatment of a broad range of patients with life-threatening cardiac rhythms.

III. PROCEDURE:

1. Participate and pass an approved AHA ACLS class at least every 2 years.

IV. QUALITY ASSURANCE:

ACLS code will be reviewed by MPD and/or designee. Deviation from a standard algorithm may require on-line physician consultation. These algorithms should not be construed as prohibiting flexibility as long as each action is justified and thoroughly documented.

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| BENTON/FRANKLIN COUNTIES POLICY # 5 | Effective Date: 1/1/98 | Page: 1 of 2 |
| SUBJECT: ALS INITIAL CERTIFICATION PREREQUISITE | | |

I. STANDARD:

To provide a uniform method for ALS EMS personnel either new to field, or new to the area, to become familiar with local, regional and state patient care protocols and procedures.

II. PURPOSE:

1. To assure EMS providers are qualified to provide an acceptable level of medical care in the prehospital setting.
2. To assure the EMS providers are familiar with local, regional and state patient care protocols and procedures.

III. PROCEDURE:

3. Prior to the MPD recommending ALS personnel for state certification and the ability to practice in Benton-Franklin Co. the following shall be accomplished.
 - a. Pass the National Registry Exam(s).
 - b. Meet all state requirements for certification identified in WAC 246-976-140 (3, 4, 5, and 6), 200 and 210.
 - c. Pass the County Protocol Exam with a minimum score of 80%.
 - d. Provide documentation of satisfactory completion in ACLS, PALS and PHTLS (or equivalent).
 - e. Provide letters of recommendation, on official letterhead, from (1) most recent employer or agency of association in the field of emergency medical service, and (2) MPD and/or Paramedic Course Instructor/Physician Advisor.
4. After the above has been accomplished and the provider receives his/her state certification card, the shall complete the following before functioning in the field in an unsupervised setting:
 - a. Render care in the field in conjunction with department approved preceptor, to a minimum of twenty (20) ALS patients.

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| BENTON/FRANKLIN COUNTIES POLICY # 5 | Effective Date: 1/1/98 | Page: 2 of 2 |
| SUBJECT: ALS INITIAL CERTIFICATION PRERQUISITE | | |

- b. ALS patient contacts shall include but are not limited to;
- 1) working at least two ACLS codes
 - 2) working at least two trauma that meet the criteria for modified or full trauma team activation at the receiving facility
 - 3) Administering medications, starting IVs, I.Os ETTs, etc.
 - 4) Demonstrate proficiency at writing MIRs and radio communication
 - 5) Meet with the MPD for an oral interview.

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| BENTON/FRANKLIN COUNTIES POLICY # 6 | Effective Date: 1/1/98 | Page: 1 of 1 |
| SUBJECT: AED & COMBI-TUBE C.E. REQUIREMENTS | | |

I. STANDARD:

All EMS providers that have special skills endorsement in AED or Combitube are required to maintain additional CME to remain certified in Benton Franklin Co.

II. PURPOSE:

To assure that providers maintain proficiency in the use of AED and/or Combitube.

III. PROCEDURE:

1. Participate in approved skill maintenance and continuing education no less than once every 90 days for the first 2 years after initial skill endorsement.
2. Subsequent years – participate in approved skill maintenance and continuing education no less than once every 180 days.
3. Training Components –AED
 - a. CE shall be completed on appropriate time schedule
 - b. Each person will be evaluated as team leader on three simulated cardiac arrest exercises to include: VF, a non-treatable rhythm, and some type of equipment malfunction or other type of problem
4. Training Components – Combi-tube
 - a. CE shall be completed on appropriate time schedule
 - b. Each person must successfully complete practical skills exam which includes intubation and extubation on an airway manikin. Practices session must include simulated “megacode” situations.
5. In the event of an actual occurrence you are required to forward within 3 days a copy of your completed report which includes the MIR, ECG tape, Audio Recording and the Benton-Franklin Co. Defibrillation/Combitube Incident Report to the Director of EMS Office for review.
6. Each individual’s CE will need to be documented and a record kept on file for audit by the MPD and/or designee.

IV. QUALITY ASSURANCE:

Actual occurrences will be reviewed on a regular basis by MPD and/or designee.

Training records will be audited for compliance. Failure to maintain CE may result in the loss of the MPD’s permission to perform these special skills.

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| BENTON/FRANKLIN COUNTIES POLICY # 7 | Effective Date: 1/1/00 | Page: 1 of 1 |
| SUBJECT: ALS CME REQUIREMENTS | | |

I. STANDARD:

Continuing education is a requirement for recertification at the state and local level.

To retain Protocol Privileges within Benton-Franklin Counties all paramedics shall document completion of a minimum of one hundred fifty hours of MPD-approved CME including state required: special emphasis on HIV/AIDS and Hepatitis B, and six hours of pediatrics. Additionally paramedics will be required to submit documentation of 48 hours of refresher training to include the following topics:

| | |
|-----------------------------------|---|
| General patient assessment | Airway management |
| Shock | General Pharmacology |
| Trauma Assessment | Injuries to the CNS |
| Thoracoabdominal trauma | Burns |
| Assessment of the medical patient | Respiratory system |
| Cardiovascular system | Nervous system |
| Endocrine system | Toxicology, alcoholism, and drug abuse |
| Environmental emergencies | Special considerations for geriatric patients |
| Gynecological problems | Obstetrics and obstetrical problems |
| Care of the neonate | Overview of behavioral emergencies |
| Psychotic disorders | The violent patient |
| Response to the crisis situation | |

II. PURPOSE:

To provide uniformed on-going continuing medical education training program that focuses on continuous quality improvement.

III. PROCEDURE:

A wide variety of formats for CE can be observed including case reviews, hands-on skill review sessions, formal lectures, **pre-approved** satellite programs and self-instructional programs.

IV. QUALITY ASSURANCE:

Evaluation shall include testing of knowledge, as well as retrospective evaluation of the care actually given to patients.

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| BENTON/FRANKLIN COUNTY POLICY # 8 | Effective Date: 1/1/01 | Page: 1 of 2 |
| SUBJECT: ALS MANDATORY MEETING REQUIREMENT | | |

I. STANDARD:

To maintain protocol privileges in Benton-Franklin Counties all paramedics are required to attend a minimum of 9 ALS meetings annually. These meetings may be either their in-house monthly paramedic meetings with their Physician Advisor or the every other month Tri-City Paramedic meeting with the MPD or a combination of both.

II. PURPOSE:

The purpose of the requirement is to insure that all Paramedics have an on-going forum to:

- Review and receive feedback on patient care issues
- Receive information on new protocols and protocol changes
- Share system problems and goals
- Have periodic formal evaluation of skills and knowledge
- Have formal lectures for CE.

III. PROCEDURE:

Attend at least 50% (a total of 9 ALS meetings annually) of the monthly in-house physician advisor meetings and/or Tri-City Paramedic meetings.

Individuals are responsible for registering their attendance at these meetings by signing the roster. The roster shall be forwarded to the local EMS office by the agency that is hosting the meeting. Your attendance will be tracked for compliance. Your agency supervisor will be notified of non-compliance to this policy. Failure to maintain these annual requirements may result in the loss of the MPD's Protocol privileges in Benton-Franklin Co. Reinstatement will occur once the provider has successfully made up the meetings missed.

For agencies that do not have an appointed Physician Advisor, but do have monthly in-house ALS meeting, they may opt for the following with ***written pre-approval from the MPD, for each CE Lecture.***

- Arrange for CE lectures to be presented by a physician or other health care professional. (Documentation of the content of the CE, duration, objectives must be pre-approved).
- Attend at least 50% (3) of the Tri-City Paramedic Meetings.

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| BENTON/FRANKLIN COUNTIES POLICY # 8 | Effective Date: 1/1/01 | Page: 2 of 2 |
| SUBJECT: ALS MANDATORY MEETING REQUIREMENT | | |

IV. QUALITY ASSURANCE:

Strive to link the CE programs to CQI. Provide a mechanism to help ensure a uniform application of performance standards and enhance a system's ability to provide quality patient care.

DIRECTION TO TAKE A BLOOD TEST

INSTRUCTIONS: This form must be completed and signed by law enforcement and returned to the attending EMS personnel. Law enforcement should provide the appropriate blood tubes.

PATIENT: _____ **DATE:** _____ **TIME:** _____

EMS AGENCY TO PERFORM PROCEDURE: _____

The undersigned states that the above named patient is either (1) unconscious or (2) under arrest for the crime of vehicular homicide as provided in RCW 46.61.520, or vehicular assault as provided in RCW 46.61.522, or that such person is under arrest for the crime of driving under the influence of intoxicating liquor or drugs as provided in RCW 46.61.502, which arrest results from an accident in which another person has been injured and there is reasonable likelihood that such a person may die as a result of injuries sustained in the accident.

The undersigned directs personnel from the above named agency to administer a blood test (draw blood) without the consent of the patient so unconscious or so arrested.

Officer: _____ **Signature:** _____

Law Enforcement Agency: _____

Yakima County Operating Procedures

| Yakima County EMS & Trauma Care Council | | | |
|---|--|---|------------------|
| COUNTY OPERATING PROCEDURE | NUMBER: 2 | SUPERSEDES NO: April 8, 1998 | PAGE: 1 of 1 |
| YAKIMA COUNTY EFFECTIVE DATE: February 14, 2001 | ADOPTED BY SOUTH CENTRAL REGIONAL EMS COUNCIL: | | APPROVED BY DOH: |
| SUBJECT: DEFINITION AND DOCUMENTATION OF EMS UNITS RESPONSE TIMES (PCP #2) | | | |
| RECOMMENDED BY: Signature: _____ Name: <u>Erik Miller, M.D.,</u> <u>FACEP</u> Title: <u>Yakima County Medical Program</u> <u>Director</u> | | RECOMMENDED BY: Signature: _____ Name: <u>Shari Davis, Chairperson</u> Title: <u>Yakima County EMS & Trauma Care Council</u> | |
| ADOPTED BY: Signature: _____ Name: <u>Cheryl Burrows, Chair, Planning & Standards</u> <u>Committee</u> Title: <u>South Central Region EMS & Trauma Care</u> <u>Council</u> | | APPROVED BY: Signature: _____ Name: _____ Title: <u>WA State DOH, Office of EMS & Trauma Prevention</u> | |

I. PURPOSE

- A. To define a standard definition of aid vehicle and ambulance response times, among all EMS organizations in Yakima County, to ensure that response data collected, will be consistent and accurate.
- B. To provide a procedure requiring the use of this definition when documenting response times on medical incident reports and other documents and materials related to emergency medical services.

II. GUIDELINES

- A. Ambulance, aid vehicle, and EMS agency **response time** (or response interval), shall be defined as: *the period between the time the call is received by the agency's dispatcher (not the 9-1-1 call-taker) and the EMS vehicle stops at the incident scene.*

III. PROCEDURES

- A. This definition shall be used for documenting response times on medical incident reports, computer databases, reports, and other documents related to emergency medical services.
- B. EMS agency dispatchers shall document ambulance and/or aid vehicle response times separate from other vehicles (e.g., command vehicles) responding to the same incident.

| Yakima County EMS & Trauma Care Council | | | |
|---|--|---|--|
| COUNTY OPERATING PROCEDURE | | NUMBER: 3A | SUPERSEDES NO: April 8, 1998 |
| PAGE: 1 of 1 | | | |
| YAKIMA COUNTY EFFECTIVE DATE: February 14, 2001 | ADOPTED BY SOUTH CENTRAL REGIONAL EMS COUNCIL: | | APPROVED BY DOH: |
| SUBJECT: DESTINATION OF PATIENT WITHOUT HOSPITAL PREFERENCE | | | |
| RECOMMENDED BY: Signature: _____ Name: <u>Erik Miller, M.D., FACEP</u> Title: <u>Yakima County Medical Program Director</u> | | RECOMMENDED BY: Signature: _____ Name: <u>Shari Davis, Chairperson</u> Title: <u>Yakima County EMS & Trauma Care Council</u> | |
| ADOPTED BY: Signature: _____ Name: <u>Cheryl Burrows, Chair, Planning & Standards Committee</u> Title: <u>South Central Region EMS & Trauma Care Council</u> | | APPROVED BY: Signature: _____ Name: _____ Title: <u>WA State DOH, Office of EMS & Trauma Prevention</u> | |

I. PURPOSE

To implement destination policies and procedures for non-traumatic and minor trauma patients without hospital preference.

II. GUIDELINES

- A. For incidents occurring in Upper Yakima County (and those that are closer to the Yakima area than the hospitals in Lower Yakima County), patients without hospital preference shall be transported to the hospital designated that day as the Trauma Facility/Medical Control Facility (MCF).
- B. For incidents occurring in Lower Yakima County, patients without hospital preference shall be transported to the closest hospital facility.
- C. If there is a potential that transportation to the closest facility would be inappropriate due to the patient's condition, then contact the MCF for advice. The on-duty emergency physician at the MCF shall determine the most appropriate hospital destination.
- D. Patients without hospital preference, who meet the trauma triage criteria as defined in the State of Washington *Prehospital Trauma Triage (Destination) Procedures*, shall be transported in accordance with the *Yakima County Triage and Transport of Trauma Patients* county operating procedure.

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|--|--|--|--|
| Yakima County EMS & Trauma Care Council | | | |
| COUNTY OPERATING PROCEDURE | | NUMBER: 6 | SUPERSEDES NO: April 8, 1998 |
| PAGE: 1 of 2 | | | |
| YAKIMA COUNTY EFFECTIVE DATE: February 14, 2001 | | ADOPTED BY SOUTH CENTRAL REGIONAL EMS COUNCIL: | |
| | | APPROVED BY DOH: | |
| SUBJECT: INTERAGENCY RADIO COMMUNICATIONS DURING EMERGENCY MEDICAL INCIDENTS (PCP #6) | | | |
| RECOMMENDED BY: Signature: _____ Name: <u>Erik Miller, M.D., FACEP</u> Title: <u>Yakima County Medical Program Director</u> | | RECOMMENDED BY: Signature: _____ Name: <u>Shari Davis, Chairperson</u> Title: <u>Yakima County EMS & Trauma Care Council</u> | |
| ADOPTED BY: Signature: _____ Name: <u>Cheryl Burrows, Chair, Planning & Standards Committee</u> Title: <u>South Central Region EMS & Trauma Care Council</u> | | APPROVED BY: Signature: _____ Name: _____ Title: <u>WA State DOH, Office of EMS & Trauma Prevention</u> | |

I. PURPOSE

To provide a policy for establishing a single countywide frequency to be used for interagency radio communications during emergency medical incidents.

II. GUIDELINES

- A. For coordination during EMS incidents, communications between fire department aid vehicles and ambulances, or between ambulances affiliated with different organizations, shall be done by utilizing the On-scene Command and Coordination Radio (OSCCR) frequency—156.135 MHz.
 1. In the event that communications cannot be established via OSCCR, the Lower Valley Fire frequency (154.385 MHz) may be used as an alternative for incidents occurring south of Union Gap, and the Upper County Fire frequency (154.190 MHz), for incidents occurring in the Upper Valley.
- B. The OSCCR frequency shall not be used for dispatching, or non-essential, non-emergency communications.

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| SUBJECT: INTERAGENCY RADIO COMMUNICATIONS DURING EMERGENCY MEDICAL INCIDENTS (PCP #6) | | | |

III. PROCEDURES

A. Licensed ambulances and aid vehicles shall install the OSCCR frequency in their mobile units.

1. Applications for installation and utilization of the OSCCR frequency shall be obtained through the *Yakima Valley Office of Emergency Management*.

B. When attempting contact via OSCCR, the vehicle initiating the call shall conclude with the phrase, "...on Oscar" (e.g., "Ambulance A from Fire Department B, on Oscar").

1. When attempting contact on an alternate frequency, the call shall conclude with the phrase, "...on Lower Valley Fire frequency," or "...on County Fire frequency (whichever is applicable).

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| COUNTY OPERATING PROCEDURE | | NUMBER: 7 | SUPERSEDES NO: April 8, 1998 | PAGE: 1 of 5 |
| YAKIMA COUNTY EFFECTIVE DATE: February 14, 2001 | | ADOPTED BY SOUTH CENTRAL REGIONAL EMS COUNCIL: | | APPROVED BY DOH: |
| SUBJECT: REQUESTING THE M.A.S.T. HELICOPTER STAFFED WITH A PARAMEDIC (PCP #7) | | | | |
| RECOMMENDED BY: Signature: _____ Name: <u>Erik Miller, M.D.,</u> <u>FACEP</u> Title: <u>Yakima County Medical Program</u> <u>Director</u> | | RECOMMENDED BY: Signature: _____ Name: <u>Shari Davis,</u> <u>Chairperson</u> Title: <u>Yakima County EMS & Trauma Care</u> <u>Council</u> | | |
| ADOPTED BY: Signature: _____ Name: <u>Cheryl Burrows, Chair, Planning & Standards Committee</u> Title: <u>South Central Region EMS & Trauma Care</u> <u>Council</u> | | APPROVED BY: Signature: _____ Name: _____ Title: <u>WA State DOH, Office of EMS & Trauma Prevention</u> | | |

I. PURPOSE

- A. To implement policies and procedures describing the indications and contraindications for requesting the M.A.S.T. Helicopter staffed with a paramedic.
- B. To provide procedures for requesting the M.A.S.T. Helicopter.
- C. To provide interagency procedures for the notification and dispatch of M.A.S.T. and a paramedic.
- D. To provide procedures for hospital destination of patients transported by the M.A.S.T. Helicopter.

II. GUIDELINES FOR UTILIZATION OF THE M.A.S.T. HELICOPTER

- A. Activation of the M.A.S.T. Helicopter may be done in the following situations (this does not include those incidents in which the helicopter is needed for rescue purposes only, and use of a paramedic is unnecessary):

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1. Serious traumatic injuries.
 - a. If M.A.S.T. is requested for trauma, the patient(s) must meet the trauma triage criteria for trauma system activation, as described in the *Washington State Prehospital Trauma Triage (Destination) Procedures*.
 - b. The helicopter must be able to access and transport the patient to an appropriate hospital facility more rapidly than a ground unit.
2. Incidents in which a patient would benefit from advanced life support (ALS), that would otherwise be unavailable from local ground units; unless ground transport would result in an earlier arrival at a local hospital facility capable of providing the necessary level of care.
3. Long-distance interfacility transfers greater than 60 minutes away from the receiving hospital by ground unit, in which the patient will require ALS while en route, as well as rapid transport.
4. Incidents occurring in remote or wilderness areas not easily accessible by ground units.
5. Multiple casualty incidents in which the helicopter would be of benefit as an additional means of transporting patients.
6. Other situations not defined in this policy, in which a patient would benefit from transport by helicopter rather than ground unit (per discretion of the incident commander).
- B. The M.A.S.T. Helicopter should not be activated for patients with minor illnesses or injuries, where immediate transport is unnecessary and ground units may be available; deceased victims; or patients in cardiopulmonary arrest.
- C. Weather, availability of a landing zone, and scene safety should be considered when requesting the M.A.S.T. Helicopter. M.A.S.T. should not be requested if any of the above (or other factors) would prohibit its utilization.

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III. REQUESTING THE M.A.S.T. HELICOPTER

- A. Any EMS provider agency may request a response from the M.A.S.T. Helicopter staffed with a paramedic. Generally, this should come from the incident commander
- B. EMS agencies and individuals shall make requests for the M.A.S.T. Helicopter by contacting either the City of Yakima or Fire District #5 fire dispatch center (depending upon the location of the incident).
- C. All other agencies may contact the Yakima County Sheriff's Office (YSO) dispatch center or one of the fire dispatch centers.

IV. ALERT PROCEDURES

- D. When M.A.S.T. is placed on *alert status*, the helicopter is readied for flight and a paramedic notified. The M.A.S.T. Helicopter will not respond until activated
- E. M.A.S.T. can be placed on alert if there is information indicating that it may be needed (e.g., unverified reports of multiple patients, serious trauma), but EMS personnel are not yet on the scene to determine the condition of the patient(s).
- F. If M.A.S.T. is requested to be placed on alert status, all agencies involved in the incident (e.g., fire department, ambulance service, law enforcement), must be informed via their respective dispatchers or through direct radio contact.
- G. If it is determined that the helicopter will not be needed, the incident commander will contact the dispatcher and have them notify M.A.S.T. immediately to stand-down.

V. ACTIVATION PROCEDURES

- H. *Activation* of M.A.S.T. means a request for an immediate response to an incident. The helicopter does not need to be placed on alert prior to activation.
- I. Ideally, trained EMS personnel should arrive at the scene and assess the patient(s) before activation of M.A.S.T. If there is reliable information that the helicopter will be needed, and EMS personnel have not yet arrived, then it can be activated.

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- J. If feasible, M.A.S.T. should be activated by those EMS personnel at the incident scene who have the highest level of training and certification.
- K. In the event M.A.S.T. is activated, all agencies involved in the incident must be informed.
- L. M.A.S.T. may be canceled in the event that the patient does not meet the criteria as outlined in Section II.A, or if conditions exist as outlined in Section II.B-C.
- M. If it is determined that the helicopter will not be needed, the incident commander will contact the dispatcher and have them notify M.A.S.T. immediately that they can cancel.
- N. Communications should be established as soon as possible between the on-scene EMS agency, responding ambulance (if applicable), and M.A.S.T.

VI. DISPATCH PROCEDURES

- O. When receiving a request for the helicopter, the fire dispatcher will ask the caller if a paramedic will be required.
- P. The dispatcher shall notify M.A.S.T. to respond, and will advise them if a paramedic has been requested.
- Q. The dispatcher will contact the appropriate ALS provider agency, which will subsequently dispatch a paramedic.
 - 1. If M.A.S.T. will need to pick up a paramedic before responding to the scene, then the company that is initially responding an ambulance to the scene, or would normally respond to that scene, shall be notified to provide a paramedic.
 - 2. If it is determined that a paramedic on a responding ground ambulance will probably arrive at the scene prior to, or shortly after the helicopter's arrival, then a second paramedic should not be picked up by M.A.S.T., unless additional personnel are needed.
- R. The dispatcher will coordinate and facilitate communication between the ALS provider agency's dispatcher and the M.A.S.T. Helicopter crew (or dispatcher).

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S. Requests received by M.A.S.T. directly.

1. In the event that M.A.S.T. receives a direct request to respond (from an agency outside Yakima County), from other than the dispatcher, and it is determined that a paramedic is needed, M.A.S.T. crew will contact a Yakima County dispatch center.
 2. The dispatcher will contact the appropriate ALS provider agency in the usual manner.
- T. The agency requesting M.A.S.T. should provide accurate map coordinates to the dispatcher, who shall provide this information to the M.A.S.T. Helicopter crew.

VII. PATIENT DESTINATION

- U. Patients who meet the *Washington State Prehospital Trauma Triage (Destination) Procedures* shall be transported to the highest level designated trauma facility within 30 minutes transport time via ground or air transport.
- V. In cases involving a critical trauma patient, consider transporting directly to Harborview Medical Center (a Level I trauma center) in Seattle, if transport time would be equal to or less than transporting to another facility in Yakima County.

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| YAKIMA COUNTY EFFECTIVE DATE: February 14, 2001 | | ADOPTED BY SOUTH CENTRAL REGIONAL EMS COUNCIL: | PAGE: 1 of 2 |
| SUBJECT: USE OF PARAMEDICS ON THE M.A.S.T. HELICOPTER (PCP #7) | | | |
| RECOMMENDED BY: Signature: _____ Name: <u>Erik Miller, M.D.,</u> <u>FACEP</u> Title: <u>Yakima County Medical Program</u> <u>Director</u> | | RECOMMENDED BY: Signature: _____ Name: <u>Shari Davis,</u> <u>Chairperson</u> Title: <u>Yakima County EMS & Trauma Care</u> <u>Council</u> | |
| ADOPTED BY: Signature: _____ Name: <u>Cheryl Burrows, Chair, Planning & Standards Committee</u> Title: <u>South Central Region EMS & Trauma Care</u> <u>Council</u> | | APPROVED BY: Signature: _____ Name: _____ Title: <u>WA State DOH, Office of EMS & Trauma Prevention</u> | |

I. PURPOSE

To implement policies and procedures allowing for the utilization of paramedics to provide prehospital emergency medical care while staffing the U.S. Army's Military Assistance to Safety and Traffic (M.A.S.T.) Helicopter.

II. GUIDELINES

- A. Paramedics, who are currently certified in Yakima County and not participating in the initial orientation process for new paramedics, may provide prehospital emergency medical care while staffing the M.A.S.T. Helicopter.
 1. While on the M.A.S.T. Helicopter, paramedics shall perform emergency medical care in accordance with Yakima County Prehospital Care Protocols.
 2. Paramedics, and their respective EMS agencies, shall maintain compliance with all pertinent Yakima County EMS & Trauma Care Council County Operating Procedures.
 3. Paramedics who regularly staff the M.A.S.T. Helicopter shall have training in aero medical patient care, helicopter operations and safety, and survival procedures. It shall be the responsibility of the paramedic's employer to ensure this training is obtained.

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| SUBJECT: USE OF PARAMEDICS ON THE M.A.S.T. HELICOPTER (PCP #7) | | | |

B. Paramedics, and their respective EMS agencies, shall abide by the rules, regulations, and agreements made by and with the U.S. Army's Medical Detachment.

If an on-duty paramedic who is staffing a primary-response ambulance or aid unit is utilized for the M.A.S.T. Helicopter, that paramedic's EMS agency shall ensure that sufficient ground units and EMS personnel remain available to respond to other usual emergency incidents.

III. PROCEDURES FOR DOCUMENTATION

A. The attending paramedic on all patients treated and/or transported by the M.A.S.T. Helicopter shall complete a medical incident report.

B. A copy of the completed medical incident report form shall be submitted on all cases involving the M.A.S.T. Helicopter, in accordance with Yakima County's quality improvement policies.

| Yakima County EMS & Trauma Care Council | | | |
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| COUNTY OPERATING PROCEDURE | NUMBER: 7B | SUPERSEDES NO: NEW | PAGE: 1 of 2 |
| YAKIMA COUNTY EFFECTIVE DATE: | ADOPTED BY SOUTH CENTRAL REGIONAL EMS COUNCIL: | | APPROVED BY DOH: |
| SUBJECT: HELICOPTER ALERT AND RESPONSE (PCP #7) | | | |
| RECOMMENDED BY: Signature: _____ Name: <u>Erik Miller, M.D., FACEP</u> Title: <u>Yakima County Medical Program Director</u> | | RECOMMENDED BY: Signature: _____ Name: <u>Al Hubert, Chairperson</u> Title: <u>Yakima County EMS & Trauma Care Council</u> | |
| ADOPTED BY: Signature: _____ Name: _____ Title: <u>South Central Region EMS & Trauma Care Council</u> | | APPROVED BY: Signature: _____ Name: _____ Title: <u>WA State DOH, Office of EMS & Trauma Prevention</u> | |

I. STANDARD

Request emergency medical helicopter to the scene of a potential trauma or medical emergency patient, as soon as possible.

II. PURPOSE

To define the criteria for request of an on-scene emergency air medical helicopter and who may initiate the request.

III. PROCEDURE

- A. On-scene emergency air medical helicopter may be requested for patients in areas greater than 20 minutes ground ambulance transport time from a hospital who meets the first 2 steps of the Washington State Trauma Triage Criteria or other injury or medical criteria that indicates rapid transport.
- B. The highest-level EMS certified person on-scene should determine the need for on-scene emergency air medical helicopter response. However, on-scene law enforcement personnel may request emergency air medical helicopter response when EMS personnel are not readily available.
- C. If emergency dispatch receives credible information regarding the seriousness of the illness or injury of a patient, they may initiate air medical transport before arrival of EMS personnel at the scene.
- D. Request for on-scene emergency air medical helicopter should be initiated through the appropriate emergency dispatch agency. The dispatching agency will provide the helicopter with the appropriate radio frequency for the on-scene EMS or law enforcement agency.

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| YAKIMA COUNTY EFFECTIVE DATE: | ADOPTED BY SOUTH CENTRAL REGIONAL EMS COUNCIL: | | APPROVED BY DOH: |
| SUBJECT: HELICOPTER ALERT AND RESPONSE (PCP #7) | | | |

- D. The emergency air medical helicopter will transport trauma patients meeting the first 2 steps of the Washington State Trauma Triage Criteria to the highest designated level trauma service within 30 minutes air transport time from the scene. If a patient (or family) requests transfer to a closer facility the air medical agency will contact medical control (within 30 minutes air transport time) for direction.
- E. Medical patients will be transported by emergency air medical helicopter to the nearest appropriate facility, per local medical control.
- F. The emergency air medical helicopter will make radio contact with the receiving trauma service at or shortly after lift off from the scene.

IV. QUALITY ASSURANCE

All emergency air medical helicopter transports, stand-bys, and cancellations will be reviewed by the Medical Program Director.

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| COUNTY OPERATING PROCEDURE | NUMBER: <div style="text-align: center;">9</div> | SUPERSEDES NO: <div style="text-align: center;">April 8, 1998</div> | PAGE: <div style="text-align: center;">1 of 2</div> |
| YAKIMA COUNTY EFFECTIVE DATE: <div style="text-align: center;">February 14, 2001</div> | ADOPTED BY SOUTH CENTRAL REGIONAL EMS COUNCIL: | | APPROVED BY DOH: |
| SUBJECT: <div style="text-align: center; padding: 5px;">PATIENTS WARRANTING ALS INTERVENTION AND TRANSPORT (PCP #9)</div> | | | |
| RECOMMENDED BY: Signature: _____ Name: <u>Erik Miller, M.D., FACEP</u> Title: <u>Yakima County Medical Program Director</u> | | RECOMMENDED BY: Signature: _____ Name: <u>Shari Davis, Chairperson</u> Title: <u>Yakima County EMS & Trauma Care Council</u> | |
| ADOPTED BY: Signature: _____ Name: <u>Cheryl Burrows, Chair, Planning & Standards Committee</u> Title: <u>South Central Region EMS & Trauma Care Council</u> | | APPROVED BY: Signature: _____ Name: _____ Title: <u>WA State DOH, Office of EMS & Trauma Prevention</u> | |

I. PURPOSE

- A. To provide guidelines for situations in which a critically ill or injured patient could benefit from advanced life support (ALS) through intervention by a paramedic.
- B. To enable access to prehospital advanced life support providers in areas not normally served by an ALS provider.

II. GUIDELINES

- A. Situations in which a critically ill or injured patient is located in the primary response area of a non-ALS (BLS or ILS) ambulance service provider, and that patient could potentially benefit from advanced life support intervention by a paramedic, an ALS aid unit or ambulance shall either be dispatched to the scene or a rendezvous point with the non-ALS ambulance.
 - 1. This shall only apply to cases in which the ALS provider can make contact with the patient in a shorter time than the patient can be transported to the hospital.
 - 2. This shall also apply when an ALS provider is available and located between the incident scene and the receiving hospital.
- B. An ALS provider may be requested in any situation, if on-scene EMS personnel (or a dispatcher with reliable information) determine that there would be a potential benefit to the patient.

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| SUBJECT: PATIENTS WARRANTING ALS INTERVENTION AND TRANSPORT (PCP #9) | | | |

III. PROCEDURES

- A. For those incidents in which it has been determined by on-scene EMS personnel that ALS intervention is not needed, then the responding ALS provider(s) may be notified and give the option to cancel.
- B. Upon arrival at the scene, if the need for ALS intervention is questionable, then the ALS provider should continue response to the scene or rendezvous with the non-ALS providers.
- C. If an ALS provider is not dispatched in accordance with the terms of this procedure, then the non-ALS ambulance providers shall document, on the medical incident report, the reason. In such cases, the medical incident report shall be submitted as an audit case in accordance with the quality improvement policy.
- D. It shall be at the discretion of the EMS providers staffing the non-ALS ambulance whether to wait for the ALS providers to arrive, or rendezvous while en route to the receiving hospital.
- E. It shall be a mutual decision of both the non-ALS ambulance providers and ALS ambulance providers whether to transfer the patient to the ALS ambulance or have the patient remain in the non-ALS ambulance and bring a paramedic and needed equipment on board. Depending upon the condition of the patient, the safest and most expeditious method shall be selected.

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| YAKIMA COUNTY EFFECTIVE DATE: February 14, 2001 | ADOPTED BY SOUTH CENTRAL REGIONAL EMS COUNCIL: | APPROVED BY DOH: | |
| SUBJECT: DOCUMENTATION OF PREHOSPITAL EMERGENCY MEDICAL CARE | | | |
| RECOMMENDED BY: | | RECOMMENDED BY: | |
| Signature: _____ | | Signature: _____ | |
| Name: <u>Erik Miller, M.D., FACEP</u> | | Name: <u>Shari Davis, Chairperson</u> | |
| Title: <u>Yakima County Medical Program Director</u> | | Title: <u>Yakima County EMS & Trauma Care Council</u> | |
| ADOPTED BY: | | APPROVED BY: | |
| Signature: _____ | | Signature: _____ | |
| Name: <u>Cheryl Burrows, Chair, Planning & Standards Committee</u> | | Name: _____ | |
| Title: <u>South Central Region EMS & Trauma Care Council</u> | | Title: <u>WA State DOH, Office of EMS & Trauma Prevention</u> | |

I. PURPOSE

- A. To provide a standard format for documenting prehospital care by emergency medical service providers of all certification levels.
- B. To provide policies and procedures for the collection of data from prehospital emergency medical reports into a central computer database.
- C. To enable EMS provider organizations to meet the data collection requirements as defined in WAC 246-976-430.

II. GUIDELINES

- A. Licensed ambulance services, aero medical services, and/or organizations providing intermediate (ILS) or advanced life support (ALS) shall utilize the *Washington Emergency Medical Services Incident Report* (DOH 530-041) form to document all prehospital incidents, transports, and interfacility transfers.
- B. Licensed non-transport, basic life support (BLS) aid services shall use a *Yakima County Emergency Medical Services approved Medical Incident Report* form to document all EMS incidents.
 - 1. Alternative incident report forms must be recommended for use by the Yakima County Medical Program Director.
 - 2. Electronic, computer-generated report forms may be utilized so long as the requirements of Section II.C.1–2 are met.

Yakima County EMS & Trauma Care Council

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| SUBJECT: DOCUMENTATION OF PREHOSPITAL EMERGENCY MEDICAL CARE | | | | |

III. GENERAL PROCEDURES

- A. For all patients admitted to a hospital emergency department, ambulance personnel must complete a WEMSIR and provide the appropriate copy to the emergency department prior to leaving the hospital.
1. If extenuating circumstances do not allow this (e.g., another emergency call, or there is an immediate need to return to their emergency response area), then the appropriate copy of the WEMSIR must be brought to the hospital as soon as is practical.
 2. The WEMSIR must be provided to the hospital within two hours of the patient's arrival at the hospital for incidents involving patients who are critical and/or will potentially be admitted.
- B. The requirements of Section III.A will not be mandatory for non-emergency transfers in which the patient is being transported back to an extended-care nursing facility (i.e., nursing home, retirement center) or private residence.
- C. All appropriate sections of the applicable report form must be completed thoroughly and accurately. The narrative shall use the SOAP charting method as the accepted method of report writing.
1. [S] - SUBJECTIVE information. That information which the patient, family, bystanders or other witnesses tell you. Age of the patient, gender, weight, chief complaint, scene description, history of the even, pertinent medical history of the patient, patient's physician, medications, allergies, other extenuating circumstances, history of smoking, if known.
 2. [O] - OBJECTIVE information. This information you find on your physical exam. Level of consciousness/psychiatric status, skin characteristics, vital signs (baseline, B/P, pulse, respirations), H.E.E.N.T., neck, spine, thoracic, abdominal, pelvic, lower extremities, upper extremities, neurological including motor and sensation, note placement of medical alert tags.

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| SUBJECT: DOCUMENTATION OF PREHOSPITAL EMERGENCY MEDICAL CARE | | |

3. [A] - ASSESSMENT. Your best guess of the patient's problem or condition. The assessment is reached by taking the subjective information and adding that to your objective information.
4. [P] - PLAN. Plan of treatment. Record of your patient care and its results. Record whether patient's condition improved, continued to decline, or stabilized. The plan must reflect all the actions of the providers at the scene.

IV. DATA COLLECTION PROCEDURES

- A. The Department of EMS shall maintain patient confidentiality in accordance with WAC 246-976-450, and any other applicable state and local regulations. Patient names shall not be published in any reports or studies.
- B. Upon request from local EMS organizations, the DEMS may initiate a data collection procedure and provide a consolidated report based on the required data.
- C. The DEMS shall ensure that mandatory trauma data received is submitted to the Washington State Department of Health, Office of EMS & Trauma Systems, in accordance with WAC 246-976-430.
- D. EMS organizations shall retain and store at least one copy of each medical incident report generated by their agency.

Walla Walla County Operating Procedures (Cops)

7/1/00

Revised: 10/02

WALLA WALLA COUNTY OPERATING PROCEDURE #001

EFFECTIVE DATE: 7/1/00

SUBJECT: DISPATCH

I. STANDARD:

Dispatch procedures will be standardized for all responses in Walla Walla County.

II. PURPOSE:

To assure the most rapid availability of appropriate EMS personnel and ambulance service to ill and injured individuals in Walla Walla County, as mandated in Washington Administrative Code for EMS and Trauma Systems (WAC 246-976).

III. PROCEDURE:

- A. The City of Walla Walla (E911) is the Dispatch Center initiating EMS responses.
- B. The Dispatch Center will dispatch appropriate EMS agency
 - 1. Selection of first responding shall be based upon declared need,(emergency vs. nonemergent)
 - 2. Jurisdiction
 - 3. Geographic factors
 - 4. Response time factors
- C. Waitsburg Ambulance Service and Walla Walla County Fire Protection District #2 are dispatched from Columbia County Dispatch Center.
- D. Two-tiered response

IV. QUALITY ASSURANCE:

- A. Dispatch communications problems will be reviewed by the Medical Program Director with Communications Center Staff and EMS providers, and reported to the Regional CQI committee for review, if necessary.
- B. Dispatch communications concerns effecting patient care will be reviewed by the Medical Program Director with Communications Center Staff and EMS providers, and reported to the Regional CQI committee for review, if necessary.

SUBJECT: PATIENT TRIAGE, TRANSPORT/HOSPITAL DESTINATION

I. STANDARD:

To provide the most appropriate patient care.

II. PURPOSE:

To define the hospital destination to determine the appropriate care for the patients of Walla Walla County in accordance to WAC 246-976-370.

III. PROCEDURE:

- A. In general, patients with non-life threatening injuries or disease states will be delivered to the hospital of their or their family's choice/or as determined by the private physician.
- B. If patient does not have hospital preference, Medical Control will be contacted to obtain destination instructions.
- C. If the patient has a hospital preference, Medical Control can change the destination based on prehospital assessment, trauma triage criteria and availability of resources at the destination hospital.
- D. If patient deferred, the ED physician acting as Medical Control shall contact, by landline, their counterpart at the other facility to confirm patient acceptance.
- E. Any head and/or spinal cord injured patient with significant deterioration in level of consciousness, localizing neurologic signs, and/or Glasgow Coma Score of less than 13, should be directed to St. Mary Medical Center, unless redirected.
- F. Patients meeting Walla Walla County Trauma Triage Procedure Step 1, Step 2 and 2A will be transported to St. Mary Medical Center.
 - 1. Patients meeting Walla Walla County Trauma Triage Procedure Step 3, destination will be determined by contacting Trauma Control at St. Mary Medical Center/ Medical Control, if at Walla Walla General Hospital, or the hospital of the patient's choice.
 - 2. VA Medical Center accepts no trauma patients meeting Walla Walla County Trauma Triage Procedures Step 1, Step 2 and Step 2A. For patients meeting other trauma criteria, contact VA Medical Center for destination.
 - 3. St. Mary Medical Center is Medical Control for Oregon Trauma patients. Units responding to Oregon trauma scenes will contact SMMC. Those patients meeting Oregon Trauma Triage Criteria will be transported to SMMC.

IV. QUALITY ASSURANCE:

- A. All Walla Walla County major trauma events will be reviewed locally and reported to the Regional CQI committee, if necessary.
- B. All Walla Walla County triage, transport and hospital destination problems will be reviewed locally and reported to the Regional CQI committee, if necessary.

SUBJECT: INTERHOSPITAL/INTERFACILITY TRANSFER

I. STANDARD:

To provide for patient's definitive diagnostic or therapeutic needs that may be beyond the capacity of one facility.

II. PURPOSE:

To identify procedures for interfacility transfers for emergency medical and trauma patients, by prehospital providers.

III. PROCEDURE:

- A. All interfacility transfers shall be in compliance with current OBRA/COBRA regulations and consistent with RCW 70.170.060(2).
- B. Transporting personnel must have adequate summary of patient's condition, current treatment, possible complications and other pertinent medical information.
- C. Treatment orders should be obtained by transporting personnel.
- D. All orders should be in writing.
- E. All patients for emergency transfer must have at least one IV in place. Orders for IV solutions composition and rate to be provided.
- F. Transfer papers shall accompany the patient.
- G. Receiving physician to be contacted prior to transfer by transferring physician.
- H. Personnel and equipment used to transfer patient shall be appropriate to the treatment needed or anticipated, during transfer.
- I. Written orders for medications not covered by County Patient Care Procedures shall accompany patient.
- J. Vital signs taken and recorded every 30 minutes. Stable, sedated mental health patients will be monitored closely and observations will be recorded as above.
- K. Restraints shall be checked every 15 minutes.
- L. All interfacility transfer patients will have vital signs taken at beginning and ending of transfer.

IV. QUALITY ASSURANCE:

- A. Interhospital/interfacility transfer problems will be reviewed locally and reported to the Regional CQI committee for review, if necessary.
- B. Interhospital/interfacility transfer problems effecting patient care will be reviewed locally and reported to the Regional CQI committee for review, if necessary.

SUBJECT: ON SCENE MEDICAL COMMAND

I. STANDARD:

Incident Command System will be initiated for all EMS responses in Walla Walla County.

II. PURPOSE:

To assure the expedient triage, treatment and transfer of patients involved in an EMS event in Walla Walla County.

III. PROCEDURE:

- A. Two-tiered response initiated
- B. First EMS provider on scene determines need for ALS
 - 1. If does not require transport or only BLS transport, if available, option to notify responding ALS unit or Dispatch to cancel
 - 2. Identify self and communicate why not needed.
- C. If BLS/ALS on scene, senior paramedic shall assume or clearly delegate medical command.
- D. If more than one provider agency responds, first EMT to arrive is medical command until EMS personnel with higher certification level arrives or until EMT in charge transfers control to a later arriving EMT.

IV. QUALITY ASSURANCE:

- A. Medical Incident Command concerns will be reviewed by the Medical Program Director, Communications Center Staff and EMS providers, and reported to the Regional CQI committee for review, if necessary.
- B. Medical Incident Command concerns effecting patient care will be reviewed by the Medical Program Director with Communications Center Staff and EMS providers, and reported to the Regional CQI committee for review, if necessary.

SUBJECT: EMS/MEDICAL CONTROL COMMUNICATION

I. STANDARD:

Communications between Prehospital personnel and Medical Control will be standardized for all patients.

II. PURPOSE:

To define methods of expedient communications between Prehospital personnel and Medical Control.

III. PROCEDURE:

- A. Contact Medical Control, or destination hospital, a minimum of three times for all complicated medical and trauma patients.
 - 1. En Route
 - 2. At the scene, with quick scene size-up
 - 3. Report with pertinent patient information

IV. QUALITY ASSURANCE

- A. Communication problems will be reviewed locally and reported to the Regional CQI committee for review, if necessary.
- B. Communications problems effecting patient care will be reviewed locally and reported to the Region CQI committee for review, if necessary.

WALLA WALLA COUNTY OPERATING PROCEDURE #007
EFFECTIVE DATE: 7/1/00

SUBJECT: HELICOPTER ALERT & RESPONSE

I. STANDARD:

Initiate a helicopter with ALS EMS personnel to the scene of a life-threatening incident as soon as deemed necessary and appropriate.

II. PURPOSE:

To define the criteria for request of on-scene ALS helicopter and who may initiate the request.

III. PROCEDURE:

- A. Any responding agency in Walla Walla County may request that a helicopter be put on standby by notifying Walla Walla County Dispatch Center. This includes law enforcement personnel.
- B. If the BLS/ALS unit at scene with the patient/s meeting life-threatening criteria as defined in the Walla Walla County Patient Care Procedures, CRITERIA FOR ALS TRANSPORT and TWO-TIERED RESPONSE DISPATCH CRITERIA FOR EMS PERSONNEL, determines that air medical transport can decrease the transport time of the patient by 15 minutes to the appropriate facility, they should contact Dispatch for an ALS helicopter to be launched. For any technical rescues, contact MAST. May be appropriate to contact MAST and MedStar/Lifeflight or other available helicopter, for same incident, in the event that a paramedic may not be available to accompany patient on MAST or if MAST unable to land in limited landing zone.
- C. The Dispatch Center will provide the helicopter with the correct radio frequency to use to contact the ground unit/s.
- D. For trauma patients, the ALS helicopter will transport the patient to the highest level designated trauma service within 30 minutes air transport time.
- E. The helicopter will make radio contact with the receiving facility as soon as possible after en route from the scene. The ground units will keep the trauma center/destination facility/medical control, informed as the incident proceeds.

IV. QUALITY ASSURANCE:

- A. Reports of all helicopter scene responses will be submitted to the regional CQI committee. These will be reviewed, with local input, to ensure the appropriate use of the helicopter. All reports will include response times, location and conditions.

SUBJECT: BLS/ILS AMBULANCE RENDEZVOUS WITH ALS AMBULANCE

I. STANDARD:

To provide available optimum care for the patient's of Walla Walla County.

II. PURPOSE:

To establish guidelines for rendezvous for patients to benefit from ALS intervention.
Requirement for all patients meeting ALS Dispatch Requirements and Criteria For ALS Transport.

III. DEFINITIONS:

- A. ALS -Advanced Life Support as defined in WAC 246-976-010.
- B. Attempted - after identification of the need for ALS intervention, every effort will be made to arrange a BLS/ILS ambulance with ALS ambulance rendezvous.
- C. BLS - Basic Life Support as defined in WAC 246-976-010.
- D. ILS - Intermediate Life Support as defined in WAC 246-976-010.
- E. Rendezvous - a pre-arranged agreed upon meeting either on scene, enroute from or another specified location.

IV. PROCEDURE:

- A. BLS/ILS ambulance may determine need for ALS ambulance rendezvous at any time.
- B. Based on updated information, ALS ambulance may be given the option to cancel.
- C. Prior to BLS/ILS ambulance transporting patient from scene, ETA of ALS shall be determined. If ETA is ≤ 5 minutes and transport time is $\Rightarrow 10$ minutes, BLS/ILS ambulance will remain at the scene until ALS arrives. (Exception: major trauma victim or patient without patent airway).
- D. Upon rendezvous, ALS provider will determine method of transport, (BLS/ILS unit vs ALS unit) in accordance with RCW 18.71.210.

V. QUALITY ASSURANCE:

- A. Any deviation from this procedure shall be reviewed by the responding agencies and the MPD.
- B. BLS/ILS rendezvous problems will be reviewed locally and reported to the Regional CQI committee for review, if necessary.
- C. BLS/ILS rendezvous problems effecting patient care will be reviewed locally and reported to the Regional CQI committee for review, if necessary.

WALLA WALLA COUNTY OPERATING PROCEDURE #010
EFFECTIVE DATE 7/1/00

SUBJECT: DOCUMENTATION AND DATA SUBMISSION

I. STANDARD:

Documentation and data submission will be standardized for all responses in Walla Walla County.

II. PURPOSE:

- A. To implement local procedures for licensed and trauma verified aid and ambulance services on medical /trauma incident report (MIR) writing and data submission in accordance with the Washington Administrative Codes (WAC 246-976-330 and 430) and South Central Region Patient Care Procedure #10.
- B. To review skill maintenance and field performance of certified personnel for quality assurance purposes (WAC 246-976-920).
- C. To encourage complete and accurate documentation of patient information and treatment.

III. PROCEDURE:

- A. An approved EMS MIR must be appropriately completed and filed for any call for EMS assistance resulting in patient contact within Walla Walla County, regardless of patient transport.
- B. This applies to BLS and ALS units.
- C. Includes public assist calls.
- D. Non-transporting agencies may use a County or State approved form.
- E. Transporting agencies will leave a copy of the patient care record at the receiving facility.
- F. Patient records are confidential. Disclosure of patient information shall be governed by applicable state and federal regulations regarding confidentiality.
- G. Copies of all records will be submitted to the Walla Walla County Office of EMS for trauma registry data submission, according to the written Data Submission Agreements. These agreements are reviewed and signed every two years.

IV. QUALITY ASSURANCE

- A. The following incidents will be reviewed:
 - 1. ALS - whenever patient is treated with medication or care is discontinued
 - 2. BLS - whenever Defibrillation is attempted. Defibrillator rhythm strips will accompany the MIR.
 - 3. Esophageal Tracheal Combitube is attempted.
 - 4. Documentation problems will be reviewed by the Medical Program Director and responding EMS personnel - BLS and ALS and reported to the Regional CQI committee for review, if necessary.
- B. Documentation problems effecting patient care will be reviewed by the Medical Program Director with the responding EMS personnel - BLS and ALS and reported to the Regional CQI committee for review, if necessary.

WALLA WALLA COUNTY OPERATING PROCEDURE #013
EFFECTIVE DATE 10/01/02

SUBJECT: EMERGENCY Interfacility Responses, Into and From, Walla Walla County

I. STANDARD:

- A. EMS transport agencies coming into, or leaving, Walla Walla County, for the purpose of emergency interfacility transports, will notify Walla Walla Dispatch Center of intent to enter or leave the county, if running with lights and/or sirens.

II. PURPOSE:

- A. Provide for the safety of crews, patients, the public and other emergency responders.

III. PROCEDURE:

- A. When enroute to a facility in Walla Walla County for purposes of patient transfer and the response requires a "Code" response, the transporting agency, or their respective dispatch center, will contact Walla Walla Dispatch Center of their code response. (509.527.1960)
- A. The information to be given to the dispatch center will include:
 - 1. Route of travel
 - 2. Destination
 - 3. Time of estimated arrival
- B. If the transporting agency will be leaving the area in a code response mode, that information will also be given to the Walla Walla dispatch center.
- C. This procedure applies to BLS and ALS units.

II. QUALITY ASSURANCE

- A. Identified agencies, not adhering to the emergency transport policy, may be subject to review by the Medical Program Director, Walla Walla County office of EMS and the Regional CQI committee, if necessary.
- B.
- C. It will be the responsibility of the Walla Walla County Department of EMS to maintain communications with surrounding agencies in the matter of the above policy.